

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
MARY			F.		ALTEVOGT		FEBRUARY 9, 1968		2b. HOUR 1:40 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		WHITE		AUGUST 5, 1893			74 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				BALTIMORE Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
TOWSON			ST. JOSEPH HOSPITAL			HOMEMAKER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
STATE MARYLAND					BALTIMORE				3501 PARKSIDE DRIVE #21214		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Joseph Murphy			Mary Kelly								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
no			216-09-9405		Wm. J. Altevogt 2313 Ravenview Rd. 21093						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Brain lesion - possible tumor											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Septicemia / Arteriosclerotic Heart Disease / Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 24, 1968, to FEBRUARY 9, 1968, that (I) (we) last saw the deceased alive on FEBRUARY 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								22c. DATE SIGNED			
DR. ALEXIS SAYOC, M.D.								FEBRUARY 9, 1968			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS			
								7620 YORK ROAD TOWSON, MD. #21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)			
burial		2/12/68		Moreland Memorial		Balto.		Md.			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212						FEB 13 1968					

02030

00130

74

X





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
02031										
1. DECEASED-NAME (Type or print) First Middle Last FLORENCE CATHERINE ARNOLD					2a. DATE OF DEATH Month Day Year 2 4 1968			2b. HOUR 12 20 PM		
3. SEX F.		4. RACE W.		5. DATE OF BIRTH 10-13-1903			6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore County Md.				
10. CITY OR TOWN OF DEATH Mt. Wilson			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mt. Wilson State Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RT. 4	
14. FATHER'S NAME First Middle Last BENJAMIN FLOHR					15. MOTHER'S MAIDEN NAME First Middle Last CARRIE FOWBLE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no			16b. SOCIAL SECURITY NO. 220-16-1580		17. INFORMANT Address Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 3, 1968, to FEB. 4, 1968, that (I) (we) last saw the deceased alive on FEB. 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W. Newcomer					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED FEB. 4-1968		
22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.					22e. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/7/68		23c. NAME OF CEMETERY OR CREMATORY DEER PARK METH. CEMETERY			23d. LOCATION (City or Town) (County) (State) SMALLWOOD, CARROLL Co. MD.			
24. FUNERAL DIRECTOR J.S. Myers, Jr. Westminster, Md.					25a. REC'D BY REGISTRAR DATE FEB 7 1968		25b. REGISTRAR'S SIGNATURE J. S. Myers, Jr.			

20130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	
Robert			P		Ash		2		Month 2 Day 68 Year 11:13aM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		Cau		February 3, 1921			46 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.			USA				Baltimore Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore Towson			Greater Balto. Medical Center			Sales man / mgr.			Cronica Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Lutherville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		115 Ardoon Road	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME	
John Ash									Jenny?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address		
No			None		186-09-7843			Family records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Intracerebral hemorrhage										
4120 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Hypertensive cardiovascular disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4438										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 2/1, 1968, to 2/2, 1968, that (I) (we) last saw the deceased alive on 2/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John E. Adams, M.D.						DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) John E. Adams, M.D.						22e. ADDRESS		6701 N. Charles Street		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Removal Burial			Feb. 6, 1968		Whitemarsh Memorial Park		Prospectville, Phila., Pa.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John Burns' Sons, Towson, Maryland						FEB 6 1968		Charles Judge		

05035

05104

John S. Adams

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>4</div> <div>1</div> <div>02105</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02093</div>											
1. DECEASED-NAME (Type or Print) <b>H. HARRY A. ASHE</b>						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <b>Feb.</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>7:30</b> P.M.		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov. 22, 1894</b>		6. AGE (In years (last birthday)) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Co.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto. Co.</b>			
10. CITY OR TOWN OF DEATH <b>Upperco</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Gorsuch Mill Rd.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Machinist</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Upperco</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>East View Dr.</b>	
14. FATHER'S NAME First <b>Isaac M.</b> Middle <b>Ashe</b> Lost						15. MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>J.</b> Lost <b>Cox</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216-28-8171</b>		17. INFORMANT ADDRESS <b>Vernon Ashe Glenarm, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun Wound 7 head</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>976X</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year <b>7:25 P.M. 2/7 19 68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Farm</b>		21f. LOCATION Street or R.F.D. No. <b>Upperco</b> City or Town <b>Balto. Co.</b> County <b>Md.</b> State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>A. M. France</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>2/7/68</b>			
EXAMINER'S NAME (Type) <b>A. M. FRANCE</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <b>PARKIN A.D.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>Feb. 9, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hampstead Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Tipbon - Eline Funeral Home Hampstead, Md.</b>						25a. REC'D BY REGISTRAR <b>FEB 14 1968</b>		25b. REGISTRAR'S SIGNATURE			

52080

20130

STATE OF  
NEW YORK



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First <b>CHARLES</b>		Middle <b></b>		Last <b>ATKALN</b>		2a. DATE OF DEATH <b>February</b> Month <b>24</b> , Day <b>1968</b>		2b. HOUR <b></b> M
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>11-28-1893</b>		6. AGE (In years last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Lavia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b>		Md.		
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Shangri La Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5434 Addington Road 21229</b>		
14. FATHER'S NAME First Middle Last <b>Unknown</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212-10-2528</b>		17. INFORMANT <b>Mrs. Hilda H. Atkain</b>		Address <b>5434 Addington Rd.</b>		21229		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C.N.A. RT.</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Age</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24h</b> <b>50</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>331X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/25</b> , 19 <b>68</b> , to <b>2/27</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>1/23</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Cliff Ratliff</b>		DEGREE <b></b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/26/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Dr. Cliff Ratliff, Jr.</b>		22e. ADDRESS <b>4605 Edmondson Avenue, Balto., Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE <b>2-27-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>				ADDRESS <b></b>		25a. REC'D BY REGISTRAR DATE <b>FEB 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

02030

02100

1000 1000 1000 1000

1000

1000 1000 1000

1000

1000

1000

1000

1000

1000

1000 1000 1000

1000

1000 1000 1000

1000 1000 1000

1000

1000

1000

1000 1000 1000 1000 1000

1000

1000 1000

1000 1000

1000 1000 1000

1000

1000

1000 1000 1000 1000

1000

1000 1000 1000

1000 1000

1000 1000

1000 1000 1000

1000 1000

1000 1000

1000 1000 1000 1000

1000 1000 1000

1000 1000

1000 1000 1000 1000

1000

1000 1000 1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR Hour Min.	
Charles Joseph Baier						February 29, 1968		8:15 p.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		May 10, 1900		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		U.S.A.				Baltimore		Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore			5104 McFaul Road #6			Salesman		Balto. Laundry	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13a. STREET AND NUMBER	
Md.		Balto.		Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5104 McFaul Road #6	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Peter Baier			Laura Walstrom						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			213-05-4778		Catherine Baier, wife, above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan, 1968, to Feb, 1968, that (I) (we) last saw the deceased alive on Feb 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. Robert Lyden					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/2/68		
22d. PHYSICIAN'S NAME (Type) Dr. Robert Lyden					22e. ADDRESS 6402 Golden Ring Road				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/4/68		Oak Lawn Cemetery		Balto., Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13					25a. REC'D BY REGISTRAR DATE MAK 5 1968		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		

70 ISO

2050

Agit. exp. novembre 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MIDDLE STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
02108										
02637										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
MARIE (MARY) B. BAUERNSCHMIDT						Month Day Year 2 3 68			8:50aM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Caucasian					62 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			
Balto., Md.		U.S.A.					Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson		Greater Balto. Med. Center			House Work			At Home.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3325 Hudson St. #21224.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last Martin Bauernschmidt			First Middle Last Anna Strugala							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No			214-03-2369		Martin J. Bauernschmidt Same.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute bacterial endocarditis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4300</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/24, 1968</u> , to <u>2/3, 1968</u> , that (I) (we) last saw the deceased alive on <u>2/3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>John E. Adams</u> DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>2/3/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>John E. Adams, M. D.</u>					22e. ADDRESS <u>Greater Baltimore Medical Center</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Burial</u>		<u>2-7-68.</u>		<u>Sacred Heart Cemetery</u>		<u>7401 German Hill Rd Md.</u>				
24. FUNERAL DIRECTOR <u>Charles J. Jailer</u>					25a. REC'D BY REGISTRAR <u>Charles J. Jailer</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jailer</u>			
					DATE <u>FEB 6 1968</u>					

10000

02107

I. 1000

1000

1000

1000

1000

1000

1000

1000

1000

*John W. Adams*

I.

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2 1 (M) 02109

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02038

1. DECEASED-NAME (Type or print) First Middle Last EMILY ELIZABETH BAUGHER			2a. DATE OF DEATH Month Day Year 2 23 68		2b. HOUR 4:55a M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH June 5, 1902		6. AGE (In years last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Lanell Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution-Residence before admission) STATE Md	13b. COUNTY Howard	13c. CITY OR TOWN Elkridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Box 241 Rt 4	
14. FATHER'S NAME First Middle Last Joseph Stevens		15. MOTHER'S MAIDEN NAME First Middle Last Nettie Castle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Lillian McQuinn, Elkridge City Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1541 IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of rectum DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 154X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1/30, 1968, to 2/23, 1968, that (I) (we) last saw the deceased alive on 2/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John E. Adams				22c. DATE SIGNED 2/23/68	
22d. PHYSICIAN'S NAME (Type) John E. Adams, M. D.				22e. ADDRESS Greater Baltimore Medical Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-26-68	23c. NAME OF CEMETERY OR CREMATORY Marianville Mem	23d. LOCATION (City or Town) (County) (State) Lanell Md		
24. FUNERAL DIRECTOR Selene Donachson		ADDRESS Lanell Md		25a. REC'D BY REGISTRAR DATE FEB 29 1968	25b. REGISTRAR'S SIGNATURE Charles J. [Signature]

00000

00000

00000



John S. Brown

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P M				
John			Baylor			February 23, 1968			12:20 P				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
M		W		11/5/1889			78 YRS.						
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Richmond, Va.			U. S. A.						Baltimore			Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Towson			329 Southwind Road			Lawyer			Law				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER	
Md.			Baltimore			Towson			YES			329 Southwind Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last										
James B. Baylor			Ellen Carter Bruce										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address							
Yes			220-44-0430T			Mrs. Sophie Fisher Baylor			(Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> <u>157.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/4 years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>157.9 none</u>													
19a. DATE OF OPERATION <u>Nov. 6, 67</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of pancreas</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, etc.) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13, 1965</u> , to <u>Feb. 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>John Tilden Howard, M.D.</u>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>Feb. 24, 1968</u>				
22d. PHYSICIAN'S NAME (Type) <u>Dr. John Tilden Howard</u>			22e. ADDRESS <u>12 E. Eager St.</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>2/26/68</u>			23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas'</u>			23d. LOCATION (City or Town) (County) (State) <u>Garrison Forest, Md.</u>				
24. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>FFB 26 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

02334

ESTIMATES OF DEATH

03110

Handwritten notes and stamps, including a large circular stamp with the word "RECEIVED" and other illegible markings.

03110

03110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
WILLIAM C. BEAL SR.					2 Month 23 Day 68 Year		M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
7	W		11/28/24		43 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
PA		U.S.				BALTIMORE Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
CATONSVILLE		720 DORCHESTER RD		STEAM FITTER		MAINT.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
MD		BALTO.		CATONSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		720 DORCHESTER RD.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
ROLLO C BEAL					NORA SMEARMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO		17520 4943		ARLENE BEAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 191X Cardiovascular failure								24h
DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Brain Tumor								3 months
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
1930								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 12/12, 1967, to 2/23, 1968, that (I) (we) last saw the deceased alive on 2/23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED						
Cliff Ratliff, Jr., M.D.		2/24/68						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
		4605 Edmondson Avenue, Balto., Md., 21229						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		2/26/68		LAKE VIEW		SPRESVILLE MD.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
E.S. MACNABB		301 FREDERICK RD 21228		DATE FEB 26 1968		Charles Judge		

00150

STATE OF TEXAS

00150

00150



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>ADDIE G. BEALL</b>			First Middle Last			2a. DATE OF DEATH <b>February</b> Month <b>29</b> , Day <b>1968</b> Year		2b. HOUR <b>6:45</b> PM	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 30, 1885</b>		6. AGE (In years lost birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Bloomsbury Retreat</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>544 Park Avenue</b>	
14. FATHER'S NAME First Middle Last <b>John J. George</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Elizabeth Raines</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>231-12-3951</b>		17. INFORMANT Address <b>Mr. Gordon Bonner, 544 Park Avenue 21204</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured ABD. ANEURYSM, AORTA</b> <b>441.2</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ATHEROSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>OCT-1967</b> <b>15 YRS.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>451X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/17</b> , 19 <b>66</b> , to <b>2/29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/17</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Paul R. Ziegler</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/29/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. Paul R. Ziegler</b>				22e. ADDRESS <b>200 Chestnut Hill Drive, City, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3-2-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Village Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Harmony Village, Virginia</b>			
24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

FOJSC

91130

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																
1. DECEASED-NAME (Type or Print)			First <b>Edward</b>			Middle <b>H.</b>			Last <b>Becker Sr.</b>			2a. DATE KNOWN OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1968</b>			2b. HOUR <b>M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12/12/07</b>		6. AGE (in years last birthday) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____		2c. DATE PRONOUNCED DEAD Month <b>Feb.</b> Day <b>23</b> Year <b>1968</b>			2d. HOUR <b>M</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Baltimore</b>				
10. CITY OR TOWN OF DEATH <b>Dundalk</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>215 Parkwood Rd.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Truck Driver- A A A</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>				13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>215 Parkwood Road</b>				
14. FATHER'S NAME First <b>Henry</b> Middle <b>E.</b> Last <b>Becker</b>				15. MOTHER'S MAIDEN NAME First <b>Virginia</b> Middle <b>Mehring</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16b. SOCIAL SECURITY NO. (If no, give year or dates of service) <b>WWII 217-26-9995</b>				17. INFORMANT (Wife) <b>Mrs. Edith Becker, 215 Parkwood Rd.</b>				ADDRESS <b>Dundalk, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>410.9 Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF <b>ACVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>420.1 Diabetes mellitus</b>												* APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year _____. _____. _____. HOUR A.M. _____ P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <b>Theodore C. Patterson</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> 105 Main Street ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>2/23/68</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk ADDRESS (Street, city, town, or county) <b>Md. 21222</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>								
24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>						25a. REC'D BY REGISTRAR <b>DA FEB 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								

59750

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT-5 (11)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
02114		02103												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
WILBERT WESLEY BEEMAN						Month Day Year 2 29 68			11:45AM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
MALE		WHITE		2/20/24/			44 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Maryland		U.S.A.				BALTIMORE COUNTY, Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
FORT HOWARD			D VET. ADM. HOSPITAL			LABORER			RAILROAD					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
MARYLAND			WASHINGTON			HAGERSTOWN			X			ROUTE 1, BLACK ROCK ROAD		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last ELIJAH BEEMAN			First Middle Last CLARA BELL CLISE											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address								
YES			WW II			218 12 58 57			CLIN.RECORDS, VA HOSP. FORT HOWARD, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY:										DAYS				
IMMEDIATE CAUSE (a) HEPATIC COMA														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										UNKNOWN				
(b) CIRRHOSIS OF LIVER														
(c) BRONCHOPNEUMONIA										RECENT				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
PULMONARY CONGESTION. BILATERAL AMPUTATION ABOVE KNEES, DUE TO TRAUMA.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 2/20/68, 19__, to 2/29/68, 19__, that (I) (we) lost saw the deceased alive on 2/29/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE								DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
PETER V. JUVAN												2/29/68		
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS						
PETER V. JUVAN, M. D.								VAH FORT HOWARD, MARYLAND						
23a. BURIAL, CREMATION, REINTERMENT		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)							
BURIAL		3-4-68		ROSE HILL CEMETERY			HAGERSTOWN, MD.							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
MINNICK FUNERAL HOME HAGERSTOWN, MARYLAND				DATE		MAR 4 1968			Charles Judge					

MEDICAL CERTIFICATION



0211

0210

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE

WHITE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Edward Lawrence Benhoff						Month Day Year February 24 1968			11:00 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		4-9-1888			79 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Baltimore, Md.		U.S.A.				Balto.			Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Towson, Maryland			St. Joseph Hospital			Patrolman - retired						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Florida <del>xxxxxx</del>			✓			Ft. Lauderdale <del>xxxxxx</del>			NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			13f. APARTMENT NUMBER			
First Middle Last			First Middle Last			16th Th. Tser.						
Adam Benhoff			Mary			16th Th. Tser.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
no			215-22-1106			Glen Arm, Md. Rd.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
						Lawrence J. Benhoff Box 610 Harford			PART I. DEATH WAS CAUSED BY:			
									IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage			
									DUE TO, OR AS A CONSEQUENCE OF			
									(b) Artio Sclerotic Cardio Vascular Disease			
									DUE TO, OR AS A CONSEQUENCE OF			
									(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
4221												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from Feb. 18th, 1968, to Feb. 24, 1968, that (X) (we) last saw the deceased alive on Feb. 24th, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			
Alexis S. Sayoc M.D.			2-24-68			Alexis S. Sayoc, M.D.			7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			2/27/68		Oaklawn Cem.			Balto.		Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Leonard J. Ruck Inc. Balto. Md.			DATE FEB 26 1968			Charles Judge						

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

021150

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02116						02105					
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>				c. LENGTH OF STAY IN 1b <b>3 WKS</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				d. STREET ADDRESS <b>534 N GLOVER ST</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>TOWSON NURSING HOME</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First <b>FRANK</b> Middle <b>JOHN</b> Last <b>BIEBEL</b>			4. DATE OF DEATH Month <b>FEB</b> Day <b>29</b> Year <b>1968</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 17 1895</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED LABOR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ACME BOX CO</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE MD</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ALOYSIUS BIEBEL</b>						14. MOTHER'S MAIDEN NAME <b>HILDEGARD FISCHER</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WORLD WAR 1 213-03578</b>		17. INFORMANT Address <b>WILLIAM L BIEBEL 534 N GLOVER ST</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensative Cardio Vascular Disease</b> <b>4129</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4221</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>Feb 10, 1968</b> , to <b>Feb 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 29, 1968</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Laurence C. Post</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>2/29/68</b>		
22c. PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>						22d. ADDRESS <b>6805 YORK ROAD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>MAR 2 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER CEM</b>			23d. LOCATION (City, town or county) (State) <b>4430 BELAIR RD MD</b>			
24. FUNERAL DIRECTOR <b>DIPPEL BROS INC 1800 E LOMBARD ST</b>						25a. REC'D BY REGISTRAR <b>MAR 1 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

08110

08110

From [illegible]

To [illegible]

Subject [illegible]

Date [illegible]

Time [illegible]

Place [illegible]

Remarks [illegible]

Signature [illegible]

Official [illegible]

Organization [illegible]

Address [illegible]

City [illegible]

State [illegible]

Zip [illegible]

Phone [illegible]

Telex [illegible]

Radio [illegible]

Mail [illegible]

Notes [illegible]

Comments [illegible]

Other [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>EARL CLAIBORNE BLANKENSHIP</b>						2a. DATE OF DEATH Month <b>2</b> Day <b>3</b> Year <b>68</b>			2b. HOUR <b>1:45 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH <b>6-29-'08</b>			6. AGE (in years last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>NORFOLK, VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.						
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GREATER BALTO. Medical Center President of CHARTER HILL CO.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>President of CHARTER HILL CO.</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>TOWSON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1601 RUXTON COURT</b>				
14. FATHER'S NAME First Middle Last <b>RUFUS - BLANKENSHIP</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>CLAIBORNE, Francis</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown <b>NA</b>		(If yes give year and dates of service) <b>NA</b>		16b. SOCIAL SECURITY NO. <b>213-10-1770</b>		17. INFORMANT <b>CHART</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>expiratory failure</b> <b>1890</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic carcinoma to lungs massive</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>hypopharynx</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypopharynx</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>180X</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 23, 1968</b> , to <b>Feb 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Francis C. Gnilon</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Feb 3, 1968</b>				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Maryland</b>						
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

40120

03113



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 2 and 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02118

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02167

1. DECEASED-NAME (Type or Print) <b>JAMES</b> First <b>WILSON</b> Middle <b>BLIZZARD JR</b> Last			2a. DATE KNOWN <input checked="" type="checkbox"/> Month <b>Feb</b> Day <b>20</b> Year <b>1968</b> 2b. HOUR <b>7:30</b> M	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>6-7-53</b>	6. AGE (in years last birthday) <b>14</b> YRS.	7c. DATE PRONOUNCED DEAD Month <b>Feb</b> Day <b>20</b> Year <b>1968</b> 2d. HOUR <b>M</b>
7a. BIRTHPLACE (State or foreign country) <b>Woodensburg, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.	
1d. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Sparks</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER
14. FATHER'S NAME First <b>James W.</b> Middle <b>Blizzard, Jr.</b> Last		15. MOTHER'S MAIDEN NAME First <b>Shirley</b> Middle <b>Helfand</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT ADDRESS <b>James W. Blizzard, Sr. Sparks, Md</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOTGUN WOUND, RIGHT UPPER THORAX</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 HRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>919.0</b>				
19a. DATE OF OPERATION <b>9/22/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>9/22/68</b> HOUR A.M. <b>9:15</b> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>ACCIDENTAL DISCHARGE OF SHOTGUN</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>HOME</b>		21f. LOCATION Street or R.F.D. No. <b>WHEELER LANE SPARKS BALTO MD</b> City or Town <b>SPARKS</b> County <b>BALTO</b> State <b>MD</b>	
22a. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2-20-68</b>
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>		ADDRESS (Street, city, town, or county) <b>BALTO MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb. 23, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Eilead</b>		23d. LOCATION (City or Town) <b>Woodensburg, Balto. Md.</b> (County) (State)
24. FUNERAL DIRECTOR <b>Wm. Cook-Brooks Towson, Towson, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>

70130

03118

FOR SALE  
Item 107



99 12611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

02119		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02168	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last MORRIS BLOCK			2a. DATE OF DEATH Month Day Year 2 28 68			2b. HOUR 4:15 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH XXXXXXXXXX		6. AGE (In years last birthday) XX XX 82 YRS.	
7a. BIRTHPLACE (State or foreign country) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.	
10. CITY OR TOWN OF DEATH RANFALLS TOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTIMORE CO. GENERAL HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WOHLMUTH CO.		12b. KIND OF BUSINESS OR INDUSTRY TAILOR	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last ISRAEL BLOCK		15. MOTHER'S MAIDEN NAME First Middle Last IDA SKIN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO			
16b. SOCIAL SECURITY NO. 212-03-2602				17. INFORMANT Address DR. PHILIP L. BLOCK, 2709 GLEN AVE. #21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of prostate DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 177X						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-26, 1968, to 2-28, 1968, that (I) (we) last saw the deceased alive on 2-28-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gracito V. Patricio				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/28/68	
22d. PHYSICIAN'S NAME (Type) GRACITO V. PATRICIO				22e. ADDRESS BALTIMORE COUNTY GENERAL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-29-68		23c. NAME OF CEMETERY OR CREMATORY AGUDAS ACHIM ANSHE SFARD, BALTIMORE, MARYLAND		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN		ADDRESS ROAD MAR		25a. REG'D BY REGISTRAR 1 1968		25b. REGISTRAR'S SIGNATURE	

02189

02189

XXXXXXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXXXXXX

XXXXXXXXXX

XXXXXXXXXX

XXXXXX

XXXXXXXXXX

XXXXXXXXXX

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02120

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02109

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year			2b. HOUR		
AUDREY			NELLIE			BODE			OF ESTI- DEATH MATED <input type="checkbox"/> 2 23 19 6810:40		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year			2d. HOUR
Female	White		55 YRS.					February 23 19 6810:40			P
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Balto., Md.			USA						Balto. Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Balto.			St. Joseph Hospital			homemaker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Balto.			Balto.			7800 Ruxway Rd.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Carl A. Clemson			Nellie C.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
no						LeRoy W. Bode			7800 Ruxway Road #4		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 4309 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Ruptured aneurysm 330x DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			February 24, 1968		
Edward F. Wilson, M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
burial			2/26/68			Parkwood			Balto., Md.		
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		
Mitchell-Wiedefeld Home						6500 York Road			FEB 29 1968		
Balto., Md. 21212									25b. REGISTRAR'S SIGNATURE		

08109

08109

Section 1, Page 1 of 1

Section 1, Page 1 of 1



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

VR A1SME (5)  
10M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH	
Matthew		F.		Bolties				Month Day Year 1968 7 3	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White	June 28, 1922		45 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD	
Maryland		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		Month Day Year 1968 3	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		508 Fairview Avenue				Road Foreman		Baltimore Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland				Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER			
First Middle Last Frederick Bolties				First Middle Last Jenny Sattler		508 Fairview Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		ADDRESS			
Yes		WWII		213-16-5077		Mrs. Elizabeth Bolties, 508 Fairview Ave.		Balto. Md. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)									
4/20 Hypertension C-V-N disease									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
443X									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
				My				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningson Ave.			
EXAMINER'S NAME (Type)				M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED			
Melvin B. Davis						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk, 2/3/68			
						ADDRESS (Street, city, town, or county) Md. 21222			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/7/68		Oak Lawn Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John J. Duda, 7922 Wise Ave. Dundalk, Md.						FEB 9 1968		F. J. Judge	

02151

021110

RECEIVED - JUNE 2, 1952

NO. 3

101010

101010

JUNE 2, 1952

NO. 3

101010

101010

101010

101010

101010

101010

101010

101010

101010

Jenny

101010

101010

101010

(101010)

101010

101010

101010

101010

101010



101010

101010

101010

101010

101010

101010

101010

101010

101010

101010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)			First <b>VINCENT</b>			Middle <b>BONOLIS</b>			Last <b>BONOLIS</b>			2a. DATE OF DEATH Month <b>February</b>			Day <b>24</b>			Year <b>1968</b>			2b. HOUR <b>12:45</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>August 20, 1913</b>			6. AGE (In years last birthday) <b>54</b> YRS.			IF UNDER 1 YEAR MONTHS <b>54</b>			IF UNDER 24 HRS. HOURS <b>54</b>			MIN.					
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>			Md.											
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Restaurateur</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Towson</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>5218 McFaul Road #6</b>											
14. FATHER'S NAME First <b>Paul</b>			Middle <b>Bonolis</b>			Last <b>Bonolis</b>			15. MOTHER'S MAIDEN NAME First <b>Anna</b>			Middle <b>Scuto</b>			Last <b>Scuto</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT <b>Paul Bonolis, 5218 McFaul Rd.</b>			Address <b>5218 McFaul Rd.</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State																	
22a. I certify that (I) (this hospital) attended the deceased from <b>February 24, 1968</b> , to <b>February 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>February 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>Jaime Singzon</i>			22c. DATE SIGNED <b>February 24, 1968</b>			22d. PHYSICIAN'S NAME (Type) <b>Jaime Singzon, M. D.</b>			22e. ADDRESS <b>7620 York Road, Towson 4, Md.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2-27-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>			23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>														
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>			25a. REC'D BY REGISTRAR <b>FEB 26 1968</b>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>																	

03130

03113

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

100-10-100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in both the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																				
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																				
CERTIFICATE OF DEATH																				
1. DECEASED-NAME (Type or print)			First <b>Robert</b>			Middle <b>F.</b>			Last <b>Bonsall</b>			2a. DATE OF DEATH Feb Month 14 Day 1968 Year			2b. HOUR 7 a.m.					
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>July 19, 1926</b>			6. AGE (In years last birthday) <b>41</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b> Md.											
10. CITY OR TOWN OF DEATH <b>Randallstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Box 355 Marriottsville Rd</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Manager</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Restuarant</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Randallstown</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>Box 355 Marriottsville Rd</b>								
14. FATHER'S NAME First <b>James J.</b>			Middle <b>Bonsall</b>			Last <b>Bonsall</b>			15. MOTHER'S MAIDEN NAME First <b>Sarah</b>			Middle <b>Wallace</b>			Last <b>Wallace</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>219-16-7787</b>			17. INFORMANT <b>Mrs. Catherine B. Bonsall</b>			Address <b>Box 355 Marriottsville Rd.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , to <b>2-14-1968</b> , that (I) (we) last saw the deceased alive on <b>2-14-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <b>Emil Valle Caverio</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>2-14-68</b>											
22d. PHYSICIAN'S NAME (Type) <b>Dr. EMIL VALLE CAVERIO</b>			22e. ADDRESS <b>Liberty Rd Randallstown, Md</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2/17/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore Maryland</b>											
24. FUNERAL DIRECTOR <b>Spring Byers</b>			ADDRESS <b>8728 Liberty Rd Randallstown, Md</b>			25a. REC'D BY REGISTRAR DATE <b>FEB 19 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											

45136

51136



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

02124

02113

1. DECEASED-NAME (Type or print) First Middle Last Carl William Bornmann			2a. DATE OF DEATH Month Day Year Feb 7 1968		2b. HOUR 2:58 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH 2/13/02		6. AGE (In years last birthday) 65 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.
10. CITY OR TOWN OF DEATH Rural Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Augsburg Home 6811 Campfield Road		12b. KIND OF BUSINESS OR INDUSTRY Optical Co.	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. George	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Louis Bornmann		15. MOTHER'S MAIDEN NAME First Middle Last Emma Deichmiller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 577-05-3086A	17. INFORMANT Address Paul A. Hauer 6811 Campfield Road 21207		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 (1) Lobar Pneumonia (Rt.) DUE TO, OR AS A CONSEQUENCE OF (b) Anterior Sclerotic Heart Burn 2 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Anterior Sclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200 Chronic Brain Syndrome					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 5, 1967, to Feb 4, 1968, that (I) (we) lost saw the deceased alive on Feb 2nd 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Earl L. Chambers M.D.		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/6/68	
22d. PHYSICIAN'S NAME (Type) Earl L. Chambers M.D.		22e. ADDRESS 4108 Liberty Hts Balto. Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/6/68	23c. NAME OF CEMETERY OR CREMATORY St Pauls		23d. LOCATION (City or Town) (County) (State) Chesapeake Md	
24. FUNERAL DIRECTOR J A Keenmann		ADDRESS 6067 Hay Rd		25a. REC'D BY REGISTRAR DATE FEB 8 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08114

08130

RECEIVED

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
02125		02114							
1. DECEASED-NAME (Type or print) <i>First</i> <u>Maria</u> <i>Middle</i> <u>Bossi</u> <i>Last</i>				2a. DATE OF DEATH <u>2</u> Month <u>17</u> Day <u>68</u> Year			2b. HOUR <u>3 P</u> M		
3. SEX <u>female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH <u>4-26-1878</u>		6. AGE (In years last birthday) <u>89</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>Italy</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Baltimore</u> Md.			
10. CITY OR TOWN OF DEATH <u>Lutherville</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>518 Towson Ave.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Lutherville</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>518 Towson Ave.</u>	
14. FATHER'S NAME <i>First</i> <u>Pasquale</u> <i>Middle</i> <u>BRESCA</u> <i>Last</i>				15. MOTHER'S MAIDEN NAME <i>First</i> <u>Carmela</u> <i>Middle</i> <u>Frasca</u> <i>Last</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>no</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>213-09-8884</u>		17. INFORMANT <u>Dana M. Powder (daughter)</u> Address <u>518 Towson Ave. Lutherville</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5-10 min.</u> <u>3 years.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>7221</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1963</u> , to <u>Feb</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 12</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James R. Powder M.D.</u>				22c. DATE SIGNED <u>2-17-68</u>		22d. PHYSICIAN'S NAME (Type) <u>James R. Powder</u>			
22e. ADDRESS <u>2 East Read St Balto 21202</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/20/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

05152

051180

REMARKS ON DATA

1. 10/10/10

2. 10/10/10

3. 10/10/10

4. 10/10/10

5. 10/10/10

6. 10/10/10

7. 10/10/10

8. 10/10/10

9. 10/10/10

10. 10/10/10

11. 10/10/10

12. 10/10/10

13. 10/10/10

14. 10/10/10

15. 10/10/10

16. 10/10/10

17. 10/10/10

18. 10/10/10

19. 10/10/10

20. 10/10/10

21. 10/10/10

22. 10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02126						02115					
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First Middle Last <b>GASPER BOTTEON SR.</b>						Month Day Year <b>FEBRUARY 10 1968</b>			P M <b>9:30</b>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
<b>MALE</b>		<b>WHITE</b>		<b>9/20/87</b>		<b>80</b> YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
<b>ITALY</b>		<b>USA</b>				<b>BALTIMORE</b> Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>FORT HOWARD</b>				<b>HOSPITAL VETERANS ADMINISTRATION</b>				<b>BRICKLAYER</b>		<b>CONSTRUCTION</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
<b>MARYLAND</b>				<b>BALTIMORE</b>		<b>BALTIMORE</b>		<b>YES</b>		<b>6111 DANVILLE AVENUE</b>	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
<b>JOHN BOTTEON</b>				<b>MARY BETTO</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
<b>YES WW I</b>				<b>212 16 9676</b>		<b>CLINICAL RECORDS VA HOSPITAL FT HOWARD, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Infarcts</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b> <b>years</b>	
332X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <b>I</b> (this hospital) attended the deceased from <b>1/25/68</b> , 19____, to <b>2/10/68</b> , 19____, that <b>I</b> (we) last saw the deceased alive on <b>2/10/68</b> , 19____, and that in <b>MD</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>I</b> (we) did <b>GOOD</b> view the body after death.											
22b. SIGNATURE <b>Mario J. Quiros</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED <b>2/11/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>MARIO J. QUIROS, M. D.</b>								22e. ADDRESS <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
<b>Burial</b>		<b>2/14/68</b>		<b>Baltimore National Cemetery</b>		<b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<b>John E. Duda Funeral Home</b>				<b>7922 Wise Avenue</b>		<b>DATE FEB 14 1968</b>					
				<b>Baltimore, Maryland</b>							

02150

DISPER

NOTES

REPORT

1000 2:30

1012

WHITE

2/20/51

10

USA

YAL

4

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012

1012



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

02127				02116					
1. DECEASED NAME (Type or print)				2a. DATE OF DEATH				2b. HOUR	
First Middle Last Robert THOMAS Botts				Feb. Month 2-11-58				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Whit		11-11-22		45 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Balto. County Gen.		GAS STATION		FETTER RICHARD KANEN			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Baltimore		Reisterstown		YES		412 Sacred Heart Lane	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Robert T. Botts				Sarah Cochrane					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		220-14-7607		MRS. SHIRLEY BOTTS		REISTERSTOWN MD. 412 SACRED HEART LANE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADRENAL INSUFFICIENCY 162.1 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC TUMOR TO ADRENALS DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF LUNG (POST COBALT) WITH METASTASES 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS - Weeks - MONTHS MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Congestion - Focal Hemorrhage and Fibrosis of lungs									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Simon Calle MD				DEGREE ATTENDING PHYS.		22c. DATE SIGNED 2-11-68			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		FEB 14, 1968		DRUID RIDGE CEMETERY		Pikesville BALTO. MD.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Newell Samuel Jones				DATE FEB 15 1968		Charles Jones			

MEDICAL CERTIFICATION

0212

0212

0212

11-11-68

11-11-68

11-11-68

11-11-68

11-11-68

11-11-68

11-11-68

11-11-68

11-11-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>02123</div> <div> <div>02117</div> <div>02117</div> </div>																							
1. DECEASED-NAME (Type or print)				First JOHN				Middle SIGLER				Last BOWMAN				2a. DATE OF DEATH 2 Month 7 Day 68 Year				2b. HOUR 9:30AM			
3. SEX Male				4. RACE White				5. DATE OF BIRTH Feb. 17, 1898				6. AGE (In years last birthday) 69 YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Harrisburg, Pa.				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Baltimore				Md.							
10. CITY OR TOWN OF DEATH Balto., Maryland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Auditor				12b. KIND OF BUSINESS OR INDUSTRY Social Security Administration				12c. STREET AND NUMBER 1314 Northview Rd.							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Baltimore				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER 1314 Northview Rd.							
14. FATHER'S NAME C. Raymond Bowman				First Middle Last				15. MOTHER'S MAIDEN NAME Mary Ella Sigler				First Middle Last											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 172-01-4375				17. INFORMANT Mrs. Olivette M. Bowman				Address (Same)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1890 IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of left kidney (hypernephroma) DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 180X																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1968, to Feb. 7, 1968, that (I) (we) last saw the deceased alive on Feb. 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE John E. Adams												DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED Feb. 8, 1968							
22d. PHYSICIAN'S NAME (Type) JOHN E. ADAMS, M.D.												22e. ADDRESS Greater Baltimore Medical Center											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 2/10/68				23c. NAME OF CEMETERY OR CREMATORY Paxtang				23d. LOCATION (City or Town) (County) (State) Harrisburg, Pa.											
24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.												25a. REC'D BY REGISTRAR DATE FEB 8 1968				25b. REGISTRAR'S SIGNATURE Charles Judge							

03130

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

03110

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02129

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

0211H

1. DECEASED-NAME (Type or Print) <b>JOHN CLAYTON BRADLEY</b>			2a. DATE KNOWN OF DEATH Month <b>Feb</b> Day <b>28</b> Year <b>1968</b>			2b. HOUR <b>2:30</b> P. M.			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>9-6-83</b>	6. AGE (in years last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Month <b>Feb</b> Day <b>28</b> Year <b>1968</b>			2d. HOUR <b>2:30</b> P. M.
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. JOSEPH Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer-retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>BALTO. BALDWIN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>LongGreen Pike</b>		
14. FATHER'S NAME First Middle Last <b>Gaston C. Bradley</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Virginia Wickline</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>None</b>		17. INFORMANT <b>Family records</b>			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRANSECTION OF SPINAL CORD</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DISLOCATION OF SIXTH CERVICAL VERTEBRA</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>880X</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>9000</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>2/26 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>FELL DOWN STAIRS</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>BALDWIN BALTO. MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>William A. Pillsbury</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>2-28-68</b>		
EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <b>BALTIMORE</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Gardens</b>			23d. LOCATION (City or Town) (County) (State) <b>Sykesville, Maryland</b>		
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>				ADDRESS			25a. REC'D BY REGISTRAR <b>MAR 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>

41286

US 150

روزنامه



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Pages 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL E

TO FUNER

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

23a. BURIAL, CREMATION,  
REMOVAL (Specify)  
**Burial**

23b. DATE  
3/2/68

23c. NAME OF CEMETERY OR CREMATORY  
Holy Rosary Cemetery

LOCATION (City or Town)	(County)	(State)

24. FUNERAL DIRECTOR	Schimunek Funeral Home 3331 Brehms Lane #13	ADDRESS
----------------------	--	---------

25a. REC'D BY REGISTRAR	25b. I
DATE <b>MAR 4 1968</b>	

25b. REGISTRAR'S SIGNATURE

*Charles Young*

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)						First		Middle	Last	2a. DATE KNOWN OF DEATH				Month	Day	Year	2b. HOUR		
<b>ZYGMUNT BEJAMIN BRATKOWSKI</b>										DATE MATED <input checked="" type="checkbox"/> 2-				1968		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				2d. HOUR			
Male		White		3-14-13		54 YRS.		MONTHS		OAYS		HOURS		MIN.		February 28, 1968 11:30 AM			
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH							
Balto., Md.				U.S.A.								BALTIMORE				Md.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY			
Dundalk				636 S. 48th Street								Bargeman				Wester Maryland R.R.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
Maryland				Baltimore				Dundalk						636 S. 48th Street					
14. FATHER'S NAME First Middle Last								15. MOTHER'S MAIDEN NAME First Middle Last											
Herman Bratkowski								Josephine Kaszuba											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
no				217-14-1862				Ave. #13 Mary V. Stachurski, sister, 2233 Kentucky											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Calcific rheumatic aortic stenosis</u> <u>3950</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic cardiovascular disease</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town				County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				Charles S. Springate				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				Charles S. Springate, M.D.				ADDRESS(Street, city, town, or county)				22b. DATE SIGNED				February 29, 1968			
23a. BURIAL, CREMATION, REMOVAL(Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				3/2/68				Holy Rosary Cemetery				Balto., Md.							
24. FUNERAL DIRECTOR				Schimunek Funeral Home				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
3331 Brehms Lane #13				MAR 4 1968				f Charles J. [Signature]											



Form with multiple sections and fields, mostly containing illegible text. Visible fragments include:

- Top left: "100-100000"
- Top right: "100-100000"
- Section 1: "100-100000"
- Section 2: "100-100000"
- Section 3: "100-100000"
- Section 4: "100-100000"
- Section 5: "100-100000"
- Section 6: "100-100000"
- Section 7: "100-100000"
- Section 8: "100-100000"
- Section 9: "100-100000"
- Section 10: "100-100000"
- Section 11: "100-100000"
- Section 12: "100-100000"
- Section 13: "100-100000"
- Section 14: "100-100000"
- Section 15: "100-100000"
- Section 16: "100-100000"
- Section 17: "100-100000"
- Section 18: "100-100000"
- Section 19: "100-100000"
- Section 20: "100-100000"
- Section 21: "100-100000"
- Section 22: "100-100000"
- Section 23: "100-100000"
- Section 24: "100-100000"
- Section 25: "100-100000"
- Section 26: "100-100000"
- Section 27: "100-100000"
- Section 28: "100-100000"
- Section 29: "100-100000"
- Section 30: "100-100000"
- Section 31: "100-100000"
- Section 32: "100-100000"
- Section 33: "100-100000"
- Section 34: "100-100000"
- Section 35: "100-100000"
- Section 36: "100-100000"
- Section 37: "100-100000"
- Section 38: "100-100000"
- Section 39: "100-100000"
- Section 40: "100-100000"
- Section 41: "100-100000"
- Section 42: "100-100000"
- Section 43: "100-100000"
- Section 44: "100-100000"
- Section 45: "100-100000"
- Section 46: "100-100000"
- Section 47: "100-100000"
- Section 48: "100-100000"
- Section 49: "100-100000"
- Section 50: "100-100000"
- Section 51: "100-100000"
- Section 52: "100-100000"
- Section 53: "100-100000"
- Section 54: "100-100000"
- Section 55: "100-100000"
- Section 56: "100-100000"
- Section 57: "100-100000"
- Section 58: "100-100000"
- Section 59: "100-100000"
- Section 60: "100-100000"
- Section 61: "100-100000"
- Section 62: "100-100000"
- Section 63: "100-100000"
- Section 64: "100-100000"
- Section 65: "100-100000"
- Section 66: "100-100000"
- Section 67: "100-100000"
- Section 68: "100-100000"
- Section 69: "100-100000"
- Section 70: "100-100000"
- Section 71: "100-100000"
- Section 72: "100-100000"
- Section 73: "100-100000"
- Section 74: "100-100000"
- Section 75: "100-100000"
- Section 76: "100-100000"
- Section 77: "100-100000"
- Section 78: "100-100000"
- Section 79: "100-100000"
- Section 80: "100-100000"
- Section 81: "100-100000"
- Section 82: "100-100000"
- Section 83: "100-100000"
- Section 84: "100-100000"
- Section 85: "100-100000"
- Section 86: "100-100000"
- Section 87: "100-100000"
- Section 88: "100-100000"
- Section 89: "100-100000"
- Section 90: "100-100000"
- Section 91: "100-100000"
- Section 92: "100-100000"
- Section 93: "100-100000"
- Section 94: "100-100000"
- Section 95: "100-100000"
- Section 96: "100-100000"
- Section 97: "100-100000"
- Section 98: "100-100000"
- Section 99: "100-100000"
- Section 100: "100-100000"

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02131

## CERTIFICATE OF DEATH

02120

1. PLACE OF DEATH a. COUNTY <u>Carroll Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Marshalltown</u>			c. LENGTH OF STAY IN 1b <u>4 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Hill Nursing Home</u>				d. STREET ADDRESS <u>Liberty Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MINERVA</u> <u>Virginia</u> <u>Brengle</u>				4. DATE OF DEATH Month <u>February</u> Day <u>27</u> , Year <u>1968</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <u>Feb. 27, 1878</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hoffman</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Cromwell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mr John E. Brengle</u> Address <u>Above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4129</u> <u>Arteriosclerosis, generalized, severe;</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic brain syndrome, ASHD, severe;</u> DUE TO (c) <u>Cardiac failure, grade 4; Cardiac arrest.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1958</u> <u>to</u> <u>2/27/68</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4200</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>  </u> to <u>2/27</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>2/27/</u> 19 <u>68</u> , and that death occurred at <u>9:30</u> M. from causes and on the date stated above.							
22a. SIGNATURE <u>Howard E. Hall</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/28/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>				22d. ADDRESS <u>Sykesville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-1-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		23d. LOCATION (City or Town) (County) (State) <u>Andover, Md.</u>		
24. FUNERAL DIRECTOR <u>Arthur H. Haight</u> <u>Sykesville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 4 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02134

02134

02134

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 08-14-2010 BY 60322 UCBAW/BJS/STP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)			First <b>Bernard</b>			Middle <b>W.</b>			Last <b>Brewer</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>12:30</b> MIN <b>a.</b>								
3. SEX <b>male</b>			4. RACE <b>white</b>			5. DATE OF BIRTH <b>March 13, 1890</b>			6. AGE (In years last birthday) <b>77</b> YRS.			IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>			IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>								
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore</b>				Md.										
10. CITY OR TOWN OF DEATH <b>Catonsville</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SPRING GROVE STATE HOSP.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>country</b>											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>				13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1117 Sargent Street</b>											
14. FATHER'S NAME, First <b>William</b>				Middle <b>E.</b>				Last <b>Brewer</b>				15. MOTHER'S MAIDEN NAME First <b>Mary</b>				Middle <b>Graves</b>				Last <b>Graves</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Army</b>				16b. SOCIAL SECURITY NO. <b>1917</b>				17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>410.9</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute,</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Ht. Dis.</b>												<b>6 yrs.</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis, Generalized, Senile</b>												<b>6 yrs.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pulmonary Emphysema, Mild.</b>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 28, 1963</b> , to <b>Feb. 20, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 20, 1968</b> , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.																							
22b. SIGNATURE <b>Anthony J. Young, M.D.</b>												22c. DATE SIGNED <b>2-20-68</b>											
22d. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>												22e. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE <b>2/24/68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>New-Cathedral Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>											
24. FUNERAL DIRECTOR <b>John F. Cowan &amp; Son Inc.</b>				ADDRESS <b>901 Hollins St.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 23 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>											



05138

05138

CHARLES M. MANN

ALL CIVIL RIGHTS VIOLATIONS

1961 8 9



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

02133		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02122			
1. DECEASED-NAME First Middle Last JAMES T. BROOKHART						2a. DATE OF DEATH 2 Month 8 Day 68 Year		2b. HOUR 7:30 PM	
3. SEX m		4. RACE W		5. DATE OF BIRTH 6/4/10		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTO. Md.			
10. CITY OR TOWN OF DEATH WOODLAWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5924 MONTGOMERY ST.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PLASTER		12b. KIND OF BUSINESS OR INDUSTRY BLDG.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN WOODLAWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 5924 MONTGOMERY ST.	
14. FATHER'S NAME First Middle Last GEORGE BROOKHART				15. MOTHER'S MAIDEN NAME First Middle Last MARY LINDENBERGER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 217-206406		17. INFORMANT Address DOROTHY BROOKHART					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease with myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs.</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH none	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1963, 19, to Feb 8, 1968, that (I) (we) last saw the deceased alive on Feb 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John A. Nesbitt Jr. M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-10-68			
22d. PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR.				22e. ADDRESS 1009 Frederick Rd., Baltimore Md 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/12/68		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City or Town) (County) (State) BALTO. CO. MD.			
24. FUNERAL DIRECTOR E.S. MALINAB				301 FREEDRICK RD 21228		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

3250

5218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

02134		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02123	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <sup>First</sup> Alberta <sup>Middle</sup> Gibbons <sup>Last</sup> Brown			2a. DATE OF DEATH Feb. Month 4 Day 1968			2b. HOUR M	
3. SEX F		4. RACE Cauc.		5. DATE OF BIRTH Oct. 27, 1898		6. AGE (In years birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 602 Squires Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 602 Squires Rd. 21204		14. FATHER'S NAME <sup>First</sup> Robert Lee <sup>Middle</sup> Gibbons <sup>Last</sup>		15. MOTHER'S MAIDEN NAME <sup>First</sup> Demereah <sup>Middle</sup> Blades <sup>Last</sup>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address Ethel B. Norris, 602 Squires Rd. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 3322 (b) Cerebral thrombosis, multiple DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) none							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from January, 19 63, to Jan. 31, 19 68, that (I) (we) last saw the deceased alive on Jan. 31, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arnold O. Wood, M.D.				22c. DATE SIGNED 2/5/68		22d. PHYSICIAN'S NAME (Type)	
22e. ADDRESS							
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE 2-7-68		23c. NAME OF CEMETERY OR CREMATORY Loudon		23d. LOCATION (City or Town) (County) (State) Baltimore, Md, Baltimore	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md.				25a. REC'D BY REGISTRAR DATE FEB 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

03124

UNITED STATES OF AMERICA

03124

1972

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

02135

02124

1. DECEASED-NAME (Type or print) <b>ANGELINE CzaJa BRZECZKO</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>12</b> , Year <b>1968</b>		2b. HOUR <b>6:05PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>October 7, 1891</b>		6. AGE (In years lost birthday) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Baltimore Co., Md.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1629 Manor Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>1100 South Ellwood Ave.</b>
14. FATHER'S NAME First Middle Last <b>Benedict CzaJa</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Madeline CzaJa</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212 18 2594</b>	17. INFORMANT Address <b>Mrs. Anna Leiben, 1629 Manor Rd. Balto Md. 21222</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Influenza</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>471X</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>481X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 6 19 68</b> , to <b>Feb 12 19 68</b> , that (I) (we) last saw the deceased alive on <b>Feb 12 19 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen C. Mackowiak</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>2-13-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>STEPHEN C. MACKOWIAK</b>				22e. ADDRESS <b>6714 HOLABIRDAU 21222</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>2-16-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		23d. LOCATION (City or Town) (County) (State) <b>Balto. Maryland 21222</b>
24. FUNERAL DIRECTOR <b>Marie Plalkowski &amp; Son 1000 S. Kenwood Ave.</b>			25a. REC'D BY REGISTRAR <b>FEB 19 1968</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02134

THE BUREAU OF HEALTH

02134

February 12, 1966

PREREG

safe

AMERICAN

16

October 1, 1961

White

Female

Salisbury, N.Y.

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 film 398 2-28-67 MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
02136 CERTIFICATE OF DEATH 02125											
1. DECEASED-NAME (Type or print) First Middle Last Nellie B. Buckingham						2a. DATE OF DEATH Month Day Year 2 10 68			2b. HOUR 4:05 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8/83		6. AGE (In years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH USA Catonsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shengri-to Nursing Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Husband			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Cecil		13c. CITY OR TOWN Westminister		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 16 Webster St.			
14. FATHER'S NAME First Middle Last Joseph Brown				15. MOTHER'S MAIDEN NAME First Middle Last Rebecca Arrington				Address			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 214-32-1460		17. INFORMANT Hosp. Chart							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 486x DO NOT WRITE IN THESE SPACES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture of Humerus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 493x <u>Urinary Tract Infection</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1/5, 1968, to 2/10, 1968, that (I) (we) last saw the deceased alive on 2/10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David E. Zickaroose						22c. DATE SIGNED 2/10/68					
22d. PHYSICIAN'S NAME (Type) DAVID E. ZICKAROOSE						22e. ADDRESS 4 VFW Lane, Ellicott City, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-13-68		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Church		23d. LOCATION (City or Town) (County) (State) Winfield - Carroll - Md.					
24. FUNERAL DIRECTOR Harry W. Haight		ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR FEB 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

05132

05132

05132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201															
02137						02126									
1. DECEASED-NAME (Type or print)				First <b>HERBERT</b>		Middle <b>C.</b>		Last <b>BURK</b>		2a. DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>68</b>			2b. HOUR <b>9:20A</b> M		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>1/3/07</b>			6. AGE (In years last birthday) <b>61</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE COUNTY, Md.</b>					
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>VET. ADM. HOSPITAL</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SILVERSMITH</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>JEWELER</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>				13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2140 WILKENS AVENUE</b>			
14. FATHER'S NAME First <b>JOHN</b> Middle <b>BURK</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>FLORENCE</b> Middle <b>TAYLOR</b> Last <b></b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes give war or dates of service) <b>WW II</b>				16b. SOCIAL SECURITY NO. <b>215 01 75 68</b>				17. INFORMANT Address <b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4389 ASPERATION PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3322 CEREBRAL ARTERIOSCLEROSIS</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>EPILEPSY DUE TO CEREBRAL INFARCTION</b>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <b>4</b> (this hospital) attended the deceased from <b>11/3/67</b> , 19____, to <b>2/25/68</b> , 19____, that <b>4</b> (we) last saw the deceased alive on <b>2/25/68</b> , 19____, and that in <b>68</b> (we) (our) opinion death occurred on the date and hour and from the causes stated above. <b>4</b> (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>John D. Talbert, M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>								22c. DATE SIGNED <b>2/26/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>								22e. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>							
23a. BURIAL, CREMATION, REBURYAL (Specify) <b>BURIAL</b>				23b. DATE <b>Feb. 29, 1968</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat'l. Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR <b>McCully-inf</b>				25a. REC'D BY REGISTRAR <b>MC CULLY FUNERAL HOME</b>				25b. REGISTRAR'S SIGNATURE <b>FEB 27 1968</b>				25c. DATE <b>FEB 27 1968</b>			

05180

05180

OFFICE OF DEATH

DATE OF DEATH: 10/10/1944  
PLACE OF DEATH: ...  
CAUSE OF DEATH: ...

NAME OF DECEASED: ...

DATE OF BIRTH: ...

PLACE OF BIRTH: ...

DATE OF DEATH: ...

PLACE OF DEATH: ...

DATE OF DEATH: ...

PLACE OF DEATH: ...

DATE OF DEATH: ...

PLACE OF DEATH: ...

U.S. DEPARTMENT OF HEALTH

OFFICE OF DEATH

DATE OF DEATH: ...

PLACE OF DEATH: ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

<div>02135</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02127</div>														
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		2b. HOUR			
Samuel			Butler						Month Day Year		5:00 a.m.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			7. IF UNDER 1 YEAR		
male			Negro			Jan. 8, 1897			71 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Georgia			U. S.						Baltimore			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Catonsville			SPRING GROVE STATE HOSP.			laborer								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Md.						Balto.			YES <input type="checkbox"/> NO <input type="checkbox"/>			3320 Remley Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Osten Butler			Sarah Baker											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
yes			W. W. I			Records: SPRING GROVE STATE HOSPITAL								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
493X														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (X) (this hospital) attended the deceased from April 29, 19 65, to 2/13, 19 68, that (I) (we) last saw the deceased alive on 2/13, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.														
22b. SIGNATURE <u>Sherwood E. Wilson</u> M.D. DEGREE										22c. DATE SIGNED 2/13/68				
22d. PHYSICIAN'S NAME (Type) Sherwood E. Wilson, M.D.										22e. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21227				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE Feb 20-1968			23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City or town) (County) (State) Baltimore City					
24. FUNERAL DIRECTOR Robert E. Williams 1701 N. Bond										25a. REC'D BY REGISTRAR FEB 16 1968			25b. REGISTRAR'S SIGNATURE Charles Judge	



05150

05150

HEAD OF STATE

OFFICE OF THE SECRETARY OF DEFENSE

SECRET

SECRET

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

02139				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				02128					
1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month Day Year				2b. HOUR M		
Herman				Clinton	Caples		Feb. 9 1968						
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 10, 1889			6. AGE (In years lost birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.						
10. CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Caton Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Caretaker			12b. KIND OF BUSINESS OR INDUSTRY Druid Ridge				
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.			13b. COUNTY Baltimore			13c. CITY OR TOWN Pikesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 715 Milford Mill Rd.			
14. FATHER'S NAME Charles C. Caples				15. MOTHER'S MAIDEN NAME Katherine Shipley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> None				16b. SOCIAL SECURITY NO. 213-12-0835		17. INFORMANT Mr. Herman Caples, 715 Milford Mill Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C. V. A</u> <u>4369</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hemiplegia</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>331X</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>1-2-</u> , 19 <u>66</u> , to <u>2-9-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-9-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Enov Valle Cervero</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 12, 1968		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery			23d. LOCATION (City or Town) (County) (State) Pikesville Baltio., Md.						
24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville, Md.</u>						25a. REC'D BY REGISTRAR DATE FEB 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

AS150

6130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Francis			A. Cavey			Feb. 9 1968			A M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			White			June 23, 1898			69 YRS.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			U.S.						Baltimore County Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville			Summit Nursing Home			Proprietor			Tavern		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Maryland			Howard			Glenelg			Rt. 144 & Folly Quarter Rd.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Dennis Cavey			Theresa								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
			213 28 3300			Sadie Cavey, Rt. 144 & Folly Quarter Rd.			Glenelg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of pharynx &amp; metastases to neck &amp; to mediastinum</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>149X</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>14 Months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>8 Feb</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8 Feb</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Robert Z. Berry</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>11 Feb. 1968</u>		
22d. PHYSICIAN'S NAME (Type) <u>Robert Z. Berry</u>						22e. ADDRESS <u>Medical Arts. Bldg., Baltimore, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			Feb. 12, 1968			St. Johns			Ellicott City, Howard Md.		
24. FUNERAL DIRECTOR <u>Harry H. Witzke, 321 Columbia Pike, City, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>13 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

02180

02180

1961

DATE

TIME

10

June 27, 1961

10:30

10:30

10:30 AM

10:30

10:30

10:30 AM

10:30 AM

10:30 AM

10:30 AM

10:30 AM

10:30 AM

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

10:30

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02141

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02130

1. DECEASED-NAME (Type or Print) <b>ANNA (CISEWSKI) CESEWSKI</b>			2a. DATE KNOWN OF ESTI-DEATH MATED <b>Feb 26 1968</b>			2b. HOUR <b>3:30 PM</b>			
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>12-25-93</b>	6. AGE (in years last birthday) <b>74 YRS</b>	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS HOURS _____ MIN _____		2c. DATE PRONOUNCED DEAD Month <b>Feb</b> Day <b>26</b> Year <b>1968</b>	2d. HOUR <b>4:30 PM</b>
7a. BIRTHPLACE (State or foreign country) <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>BALTIMORE</b> Md.			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>131 TREGARONE RD.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>621 S. MONTFORD AVE</b>		
14. FATHER'S NAME First <b>FRANK WOJCIECHOWSKI</b> Middle _____ Lost _____				15. MOTHER'S MAIDEN NAME First <b>MARYANNA LISOWSKI</b> Middle _____ Lost _____					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>WALTER J. CESEWSKI</b> ADDRESS <b>7614 SPRUCE RD.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE OF BRAIN</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>880X</b> (b) <b>SKULL FRACTURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9000</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year <b>3:30 AM 2/26 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>FELL DOWN STAIRS</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>HOME</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>121 TREGARONE Timonium BALTO. Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>William A. Pillsbury</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>2-26-68</b>			
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county)						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3/1/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD.</b>			
24. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>			ADDRESS <b>2525 FLEET ST</b>			25a. REC'D BY REGISTRAR <b>MARK</b> DATE <b>5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

02120

02120 10 21 1950

02120

02120





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

02142										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										02131														
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR M														
1. DECEASED-NAME (Type or print) First Middle Last LEROY J CHESTER										2a. DATE OF DEATH Month Day Year 2-26-68										2b. HOUR M														
3. SEX male					4. RACE white					5. DATE OF BIRTH 10-30-1905					6. AGE (In years lost birthday) 62 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Baltimore County Md.																			
10. CITY OR TOWN OF DEATH Parkville					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 3108 Acton Road					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) chauffer					12b. KIND OF BUSINESS OR INDUSTRY newspaper																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Baltimore					13c. CITY OR TOWN Parkville					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 3108 Acton Road														
14. FATHER'S NAME First Middle Last Charles F. Chester					15. MOTHER'S MAIDEN NAME First Middle Last Frances E. Franz					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) no										16b. SOCIAL SECURITY NO. 212-03-0386					17. INFORMANT family Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.																																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163x																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																								
22a. I certify that (I) (this hospital) attended the deceased from <u>2 Sept</u> , 19 <u>64</u> , to <u>27 Feb</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>28 Feb</u> , 19 <u>68</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.																																		
22b. SIGNATURE <u>Howard Goodman</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															22c. DATE SIGNED <u>27 Feb 68</u>																			
22d. PHYSICIAN'S NAME (Type) Howard Goodman															22e. ADDRESS 8604 Harford Rd., Balto., Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial					23b. DATE 2-29-68					23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery					23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland																			
24. FUNERAL DIRECTOR CHARLES F. EVANS & SON 8802 Harford Rd.															25a. REC'D BY REGISTRAR DATE FEB 28 1968					25b. REGISTRAR'S SIGNATURE <u>Charles Evans</u>														

05135

COMMITTEE OF DEATH

05135

LEWIS & CLARK

WATER

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH				02132							
1. DECEASED-NAME (Type or print)		First <b>ROSE</b>		Middle <b>E</b>		Last <b>CLOSE</b>		2a. DATE OF DEATH Month <b>2</b> Day <b>11</b> Year <b>1968</b>		2b. HOUR <b>10</b> A.M.	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Aug 6, 1884</b>		6. AGE (In years lost birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Balto.</b> Md.					
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Summitt Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> <b>5009 Elmer Ave.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>5009 Elmer Ave.</b>			
14. FATHER'S NAME First <b>George Airey</b>		Middle <b>George Airey</b>		Last <b>George Airey</b>		15. MOTHER'S MAIDEN NAME First <b>Catherine Viemyer</b>		Middle <b>Catherine Viemyer</b>		Last <b>Catherine Viemyer</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Elizabeth Glass, 5631 Oregon Ave. 21227</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>486X</b> IMMEDIATE CAUSE (a) <b>Pneumonia L. lung.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 wks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>492X Hypertrophic cardiomyopathy; A.S.C.D.</b>											
19a. DATE OF OPERATION <b>Feb 13, 1968</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Heart</b>		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 13, 1968</b> to <b>Feb 11, 1968</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Feb 8, 1968</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Earl Pass</b>		22c. DATE SIGNED <b>2-11-68</b>		22d. PHYSICIAN'S NAME (Type) <b>I. EARL PASS</b>							
22e. ADDRESS <b>400, W. Johns Ave</b>		22f. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/14/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>B. Vernon Lemmon</b>		ADDRESS <b>4611 Park Heights Av. Balto. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>					

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

05143

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02144

02133

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONS VILLE</b> c. LENGTH OF STAY in lb <b>1 year 6 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Grove State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD COUNTY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.D. #1 Whitehall, Md. Norrisville</b> d. STREET ADDRESS <b>Norrisville Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELIZABETH MAY COFIELD</b>				4. DATE OF DEATH Month <b>2</b> Day <b>22</b> Year <b>1968</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-22-98</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GARRETT TICE</b>				14. MOTHER'S MAIDEN NAME <b>Aberella Slocum</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-14-4827</b>		17. INFORMANT <b>Thomas P. Cofield</b> Address <b>Spring Grove State Hosp Baltimore Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive heart infarction</b> <b>4109</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> (b) <b>Heart failure</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-19</b> , 1966, to <b>2-22</b> , 1968, that (I) (we) last saw the deceased alive on <b>2-22</b> 1968, and that death occurred at <b>8:35 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Narciso Aristigueta</b>				22b. DATE SIGNED <b>2/22/1968</b>		22c. PHYSICIAN'S NAME (Type) <b>NARCISO ARISTIGUETA</b>	
22d. ADDRESS <b>SPRING GROVE STATE HOSP.</b>		22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/24/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ayres Chaple</b>		23d. LOCATION (City or Town) (County) (State) <b>Shawsville, Harford, Md.</b>	
24. FUNERAL DIRECTOR <b>Charles E. Kurtz Jarrettsville, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>	

00130

CENTRAL OF DEATH

00130

00130

00130

00130

00130

00130



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02145

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02134

1. DECEASED-NAME (Type or Print) <i>Risdon Hayes Coleman</i>			2a. DATE KNOWN OF DEATH Month <i>2</i> Day <i>18</i> Year <i>1968</i>			2b. HOUR Day <i>4</i> PM			
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>May 2, 1894</i>	6. AGE (In years last birthday) <i>68</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <i>2</i> Day <i>18</i> Year <i>1968</i>			2d. HOUR Day <i>6</i> PM
7a. BIRTHPLACE (State or foreign country) <i>Mo.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Baltimore</i> Md.			
10. CITY OR TOWN OF DEATH <i>Woodlawn</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>5311 Lewellen</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Office</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>B&amp;O RR</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>			13b. COUNTY <i>Balto</i>		13c. CITY OR TOWN <i>Woodlawn</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>5311 Lewellen Ave.</i>		
14. FATHER'S NAME First <i>Harry G.</i> Middle <i>Coleman</i> Last <i>Coleman</i>				15. MOTHER'S MAIDEN NAME First <i>Sarah L.</i> Middle <i>Bauscher</i> Last <i>Bauscher</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>705.05.2473</i>		17. INFORMANT <i>Irma R. Coleman</i> Same as 13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4129</i> IMMEDIATE CAUSE (a) <i>Cardio-Vascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4221</i>									
19a. DATE OF OPERATION <i>4/22/68</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year Hour A.M. <i>19</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.			City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>James N. Frederick</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>2/19/68</i>		
EXAMINER'S NAME (Type) <i>James N. Frederick</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
				ADDRESS (Street, city, town, or county) <i>1311 Francis Ave Balto. MD 21222</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/21/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>			23d. LOCATION (City or Town) (County) (State) <i>Baltimore Balto. Md.</i>		
24. FUNERAL DIRECTOR <i>J.T. Stansbury</i>				ADDRESS <i>6411 Windsor Mill Rd.</i>			25a. REC'D BY REGISTRAR DATE <i>FEB 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

08134

08134

08134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR			
Peter Constantinides						Feb. 18, 1968		7:40 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
Male		White		Nov. 12, 1883		84 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Turkey		USA				Baltimore		Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Lutherville			108 W. Seminary Ave.			Retired owner Restaurant					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.					Balto.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3047 Northern Parkway		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Gus Kosta Constantinides			Despina Anash								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address			
No			219-32-1473			Mrs. Mary Pillas		108 W. Seminary Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										3 months	
IMMEDIATE CAUSE (a) 1621 Carcinoma of the lungs, metastatic											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
163X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from Nov 13, 19 52, to Feb 18, 19 68, that (I) (we) last saw the deceased alive on Feb 18, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
E. J. Alessi M.D.		2/20/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
E. J. Alessi M.D.		6217 Harford Rd. Balto. Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		2/22/68		Greek Orthodox Cemetery		Baltimore, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Leonard J. Ruck, Inc.		Balto. Md. 21214		DATE FEB 20 1968		Charles Judge					

05132

05130

UNITED STATES OF AMERICA

*[Faint, mostly illegible text, possibly a letter or report, with some handwritten notes and signatures visible.]*

05130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
02147		02136									
1. DECEASED-NAME (Type or print) <b>Elizabeth</b> <b>Coupling</b>						2a. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1968</b>			2b. HOUR <b>11:50</b>		
3. SEX <b>Female</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>4-26-1905</b>			6. AGE (In years last birthday) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Baltimore</b> Md.					
10. CITY OR TOWN OF DEATH <b>Towson, Maryland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>7405 Beech Avenue</b>			
14. FATHER'S NAME First <b>Anderson</b> Middle <b>Beasley</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>Beasley</b> Last <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Wanda Shawell, 922 Denques Rd.</b> Address <b>121220</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>2509</b> <del>DIABETES MELLITUS</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes mellitus.</b> <del>DIABETES MELLITUS</del> (c) <b>Kimmelstiel Wilson disease.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 23, 1968</b> , to <b>2-23-</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2-23-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Jaime M. Singzon, M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>February 23, 1968</b>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>7620 York Road, Towson, Maryland 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Feb 27, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharp Street Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Chase Md.</b>					
24. FUNERAL DIRECTOR <b>Joseph T. Elickson</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 27 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

1012

WATER OF THE

02195

1012

WATER OF THE

02195



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove catalog pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
				Month	Day	Year							
Katherine				H		Cover	2	22	68	5:15 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMale		White		April 16, 1880			87 YRS.		MONTHS	DAYS	HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Penna.		U.S.A.				Baltimore Md.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Catonsville			Caton Ridge Nursing Home			Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland						Baltimore				3201 Batavia Ave			
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME				First	Middle	Last
Charles				M		Corwell	Anna				J		Kane
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address							
No				212-22-4610B		Raymond G Cover 2908 Dunbrin Court 21222							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4109 Pneumonia Congestive Heart Failure Arteriosclerosis										2 days 1 1/2 yrs 30 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
4201 Previous myocardial Infarction													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from August 9, 1967, to 2/22, 1968, that (I) (we) last saw the deceased alive on 2/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE										22c. DATE SIGNED			
David E. Zickel										2/23/68			
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS			
David E. Zickel										445 W. Lane, Ell City, Md. 21043			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial		2/26/68		Parkwood			Baltimore Maryland						
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Leonard J Rueck Inc Baltimore, Maryland						DATE FEB 23 1968		J Charles Judge					

02150

5. 2. 1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |   |  |   | 02138  |   |
|--|---|--|---|--|---|
| 1. DECEASED-NAME (Type or print) <b>COXE</b> First <b>CALLYSTA</b> Middle <b>AHELEN</b> Last   |   |  | 2a. DATE OF DEATH Month <b>2</b> Day <b>25</b> Year <b>68</b>   |  | 2b. HOUR <b>11:30 PM</b>                                |
| 3. SEX <b>Female</b>   | 4. RACE <b>white</b>  | 5. DATE OF BIRTH <b>11/4/15</b>  |   | 6. AGE (In years last birthday) <b>52</b> YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH <b>Baltimore County, Md.</b>   |  |   |
| 10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson St. Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House wife</b> | 12b. KIND OF BUSINESS OR INDUSTRY              |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> 13b. COUNTY <b>ST. MARY</b>  | 13c. CITY OR TOWN <b>LEONARDTOWN</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 13e. STREET AND NUMBER <b>BOX 64</b>  |  |   |
| 14. FATHER'S NAME First <b>DAVID</b> Middle <b>WILLIAM</b> Last <b>COXE</b>  |   | 15. MOTHER'S MAIDEN NAME First <b>GREEN</b> Middle <b>ADA</b> Last   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |   | 16b. SOCIAL SECURITY NO. <b>216-01-8855</b>  | 17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>493X</b> IMMEDIATE CAUSE (a) <b>STATUS ASTHMATICUS</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRONCHIAL ASTHMA</b><br>stating the underlying cause last. (c)   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>241X</b>  |   |  |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>                           |  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-12</b> , 19 <b>68</b> , to <b>2-25</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-25</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |   |  |   |
| 22b. SIGNATURE <b>W Newcomer</b>   |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   | 22c. DATE SIGNED <b>2-26-68</b>   |  |   |
| 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>   |   | 22e. ADDRESS <b>Mount Wilson, Maryland</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  | 23b. DATE <b>2-25-1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST BURIAL PARK</b>  | 23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>                                      |  |   |
| 24. FUNERAL DIRECTOR <b>Daniel Funeral Home</b>  |   | ADDRESS <b>Frostburg, Md.</b>  | 25a. REC'D BY REGISTRAR DATE <b>FEB 29 1968</b>   | 25b. REGISTRAR'S SIGNATURE <b>Charles</b>      |   |

MS126

MS126

MS126

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |   |  |  |
|--|--|--|--|--|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |  |  |
| 02150  |  | 02139  |  |  |  |   |  |   |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  | First Middle Last  |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |  |
| SUE  |  |  |  | E. CRAUMER   |  | Month Day Year<br>February 6, 1968  |  | M   |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| Female   |  | White  |  | Sept. 24, 1886   |  | 81 YRS.   |  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |   |  |  |
| Penn.  |  | U.S.A.   |  |  |  | Baltimore Md.   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                       |  |  |
| Timonium   |  |  | 5 Northwood Drive  |  |  | Housewife   |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER                       |  |
| Maryland   |  |  | Baltimore  |  | Timonium   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |   | 5 Northwood Drive                            |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |   |  |   |  |  |
| William Craumer  |  |  |  | Alice Hedrick  |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |   |  |   |  |  |
| No   |  |  | 215-56-4454T   |  | Mrs. Fannie Tracey 5 Northwood Dr. 21093                               |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u>   |  |  |  |  |  |   |  |   |  |  |
| 4120 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |   |  |   |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  |  |
| (c)  |  |  |  |  |  |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |  |  |   |  |   |  |  |
| 443X   |  |  |  |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |  |  |
|  |  |  |  |  |  |   |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |   |  |   |  |  |
|  |  |  |  |  |  |   |  |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |  |  |
|  |  |  |  |  |  |   |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-8-</u> , 19 <u>68</u> , to <u>2-6-</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>2-5-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |  |
| 22b. SIGNATURE <u>M. X. Quinn MD</u> DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  |  |   |  | 22c. DATE SIGNED <u>2-7-68</u>                          |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>M. KEVIN QUINN MD</u>  |  |  |  |  |  |   |  | 22e. ADDRESS  |  |  |
|  |  |  |  |  |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |   |  |  |
| Burial   |  | 2/9/68   |  | Jessop Methodist Cemetery  |  | Cockeysville, Md.   |  |   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |
| Wm. Cook-Brooks Towson 1050 York Rd. 21204   |  |  |  | DATE <u>FEB 13 1968</u>  |  | <u>Charles Judge</u>  |  |   |  |  |

05130

05130

05130

05130

05130

05130

05130

05130

05130

05130



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02151

CERTIFICATE OF DEATH

02140

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Towson</i>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Monkton</i>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Chesapeake Manor Nursing Home</i>   |   | d. STREET ADDRESS<br><i>Carroll Road</i>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Belle</i> Middle <i>Martin</i> Last <i>Crockett</i>  |   | 4. DATE OF DEATH<br>Month <i>February</i> Day <i>15</i> Year <i>1968</i>  |   |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Sept. 23, 1885</i>                             |
| 9. AGE (In years last birthday)<br><i>82</i> yrs.  |   | 10. IF UNDER 1 YEAR<br>Months <i>2</i> Days <i>19</i>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>Maryland</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   |
| 13. FATHER'S NAME<br><i>John Martin</i>  |   | 14. MOTHER'S MAIDEN NAME<br><i>Matilda McGadden</i>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><i>No</i>   |   | 16. SOCIAL SECURITY NO.<br><i>None</i>  |   |
| 17. INFORMANT<br><i>Family records</i>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><i>4389 Cerebral Vascular Accident</i><br>IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i><br>DUE TO (b) <i>Generalized Cerebral vascular disease</i><br>DUE TO (c) <i>10 years</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>331X Diabetes Mellitus</i>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <i>19</i>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><i>Walter T. Kees</i>  |   | 22b. DATE SIGNED<br><i>15 February 1968</i>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><i>WALTER T. KEES</i>  |   | 22d. ADDRESS<br><i>Cockeyville, Md</i>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   | 23b. DATE THEREOF<br><i>Feb. 17, 1968</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>London Park Cemetery</i>   | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Md</i> |
| 24. FUNERAL DIRECTOR<br><i>John Burns' Sons, Towson, Maryland</i>  |   | 25a. REC'D BY REGISTRAR<br><i>Charles Jones</i>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Jones</i>   |   | DATE<br><i>FEB 20 1968</i>  |   |

CS121

03120

SEP 30 1988

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

| MAY 21 1968<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                  |  |  |   |  |  |  |   |   |  |
|--|------------------|--|--|---|--|--|--|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |  |   |  |  |  |   |   |  |
| 1. DECEASED-NAME<br>(Type or Print) <i>Donald Norval Crosby, SR.</i>   |                  |  | First Middle Last  |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <i>2/18 1968</i>                            |  | 2b. HOUR <i>3:00 P.M.</i>   |   |  |
| 3. SEX <i>M</i>  | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>AUG. 24, 1917</i>  | 6. AGE (In years last birthday) <i>50 YRS.</i>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year <i>2/18 1968</i>  |  | 2d. HOUR <i>4:00 P.M.</i>   |   |  |
| 7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>  |                  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Baltimore</i> Md.  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH <i>Woodlawn</i>  |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>DOGWOOD ROAD</i> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>CHAUFFEUR</i>               |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>TRUCKING</i>                                   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>  |                  |  | 13b. COUNTY <i>Balto.</i>  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER <i>8120 Old Philadelphia Rd</i>        |  |
| 14. FATHER'S NAME<br>First Middle Last <i>GARDNER CROSBY</i>   |                  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last <i>LILLIAN HARPER</i>                              |   |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>   |                  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS<br><i>MRS. ETHEL M. CROSBY, SAME AS 13A,B,E</i>                    |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>multiple Traumatic Injuries</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>8169</i><br>(b) <i>Automobile Accident (TRUCK)</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>8220</i>                     |                  |  |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>sudden</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |                  |  |  |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  |  | 21b. TIME OF INJURY Month, Day, Year<br><i>3:00 P.M. 2 18 68</i>                                 |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><i>Truck overturned on deceased</i> |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)<br><i>dogwood Road</i> |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><i>Woodlawn Balto Md</i> |  |  |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |  |  |   |  |  |  |   |   |  |
| ACTUAL SIGNATURE <i>James N. Frederick</i>   |                  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  | 22b. DATE SIGNED <i>2/19/68</i>  |  |   |   |  |
| EXAMINER'S NAME (Type) <i>James N. Frederick</i>   |                  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>1311 Fumais Ave. Balto Md. 21227</i>                    |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>  |                  |  | 23b. DATE <i>FEB. 20, 1968</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY <i>SUNNYRIDGE CEMETERY</i>                            |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>CRISFIELD - SOMERSET - MD.</i>  |   |  |
| 24. FUNERAL DIRECTOR<br><i>BRADSHAW &amp; SONS - CRISFIELD, MD.</i>  |                  |  |  |   | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>FEB 23 1968</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>            |  |

05125

RECEIVED

05125

05125



05125

05125

05125

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

| <div>Item 18 film 398</div> <div>3-5-68 mt 02153</div> <div>02142</div>   |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
|---|--|---------|--|--|--|--|--|--|--------|---|--|--|--|------------------------|--|-------|--|
| <div>Item 18 film 398</div> <div>3-5-68 mt 02153</div> <div>02142</div>   |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| 1. DECEASED-NAME (Type or Print)  |  |         |  |  |  | First  |  |  | Middle |   |  | Last   |  |                        |  |       |  |
| NORMAN  |  |         |  |  |  | ALIEN  |  |  | CROSS  |   |  |  |  |                        |  |       |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)                                |  | IF UNDER 1 YEAR MONTHS   |        | IF UNDER 24 HRS HOURS   |  | 2c. DATE PRONOUNCED DEAD   |  | 2b. HOUR               |  |       |  |
| Male  |  | White   |  | Nov. 21, 1966  |  | 1 YRS  |  |  |        |   |  | Month Day Year   |  | 6 8 10 : 40            |  |       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |        |   |  | 9. COUNTY OF DEATH   |  |                        |  |       |  |
| Maryland  |  |         |  | U.S.A.   |  |  |  |  |        |   |  | Balto.   |  |                        |  |       |  |
| 10. CITY OR TOWN OF DEATH   |  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |        |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |       |  |
| Reisterstown  |  |         |  | D.O.A. at Dr. McWilliams   |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN  |        |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |       |  |
| Md.   |  |         |  | Balto.   |  |  |  | Reisterstown   |        |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 309 Leyton Rd.         |  |       |  |
| 14. FATHER'S NAME   |  |         |  |  |  | First  |  |  | Middle |   |  | Last   |  |                        |  |       |  |
| Don   |  |         |  |  |  | Allen  |  |  | Cross  |   |  |  |  |                        |  |       |  |
| 15. MOTHER'S MAIDEN NAME  |  |         |  |  |  | First  |  |  | Middle |   |  | Last   |  |                        |  |       |  |
| Toshiko   |  |         |  |  |  | Taketomi   |  |  |        |   |  |  |  |                        |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |         |  |  |  | 16b. SOCIAL SECURITY NO.                                       |  |  |        |   |  | 17. INFORMANT ADDRESS  |  |                        |  |       |  |
| No  |  |         |  |  |  | None   |  |  |        |   |  | Don A. Cross 309 Leyton Rd. Reis.Md.   |  |                        |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |  |  |  |  |  |        |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                        |  |       |  |
| PART I. DEATH WAS CAUSED BY:  |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| IMMEDIATE CAUSE (a) Interstitial pneumonia  |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| 484X  |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| (b) Acute enteritis   |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| (c)   |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| 525X  |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| 19a. DATE OF OPERATION  |  |         |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?              |  |  |        |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |                        |  |       |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |         |  |  |  | 21b. TIME OF INJURY Month, Day, Year                           |  |  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |  |  |                        |  |       |  |
|   |  |         |  |  |  | HOUR A.M. P.M.   |  |  |        | 19  |  |  |  |                        |  |       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |         |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  |  | 21f. LOCATION Street or R.F.D. No.   |        |   |  | City or Town   |  | County                 |  | State |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |         |  |  |  |  |  |  |        |   |  |  |  |                        |  |       |  |
| ACTUAL SIGNATURE  |  |         |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                |  |  |        |   |  | 22b. DATE SIGNED   |  |                        |  |       |  |
| EXAMINER'S NAME (Type)  |  |         |  |  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  |        |   |  | February 14, 1968  |  |                        |  |       |  |
| Edward F. Wilson, M.D.  |  |         |  |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>               |  |  |        |   |  | ADDRESS (Street, city, town, or county)  |  |                        |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                             |  |  |        | 23d. LOCATION (City or Town) (County) (State)                                   |  |  |  |                        |  |       |  |
| Burial  |  |         |  | Feb. 16, 1968  |  | Meadowridge Mem. Park  |  |  |        | Howard County, Maryland   |  |  |  |                        |  |       |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |         |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |        | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                        |  |       |  |
| H. J. Echhardt  |  |         |  |  |  | OWINGS Mills, Md.  |  |  |        | FEB 19 1968   |  |  |  |                        |  |       |  |

02153

02153

FOR THE  
RECORD

TO : [illegible]  
FROM : [illegible]  
SUBJECT : [illegible]  
DATE : [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several lines of text, some of which may be headings or body text, but they cannot be accurately transcribed.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |   | 2b. HOUR P.  |  |  |
| Catherine   |  |  | M. Crouse  |  |  | Feb. 10, 1968  |  |   | 1:40 P.  |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years lost birthday)  |  |  |
| Female  |  |  | White  |  |  | April 17, 1916   |  |   | 51 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH   |  |  |
| Maryland  |  |  | U. S. A.   |  |  |  |  |   | Baltimore Md.  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Dundalk   |  |  | 6745 Roberts Ave.  |  |  | Reproduction - Baltimore Co.   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| Maryland  |  |  | Baltimore  |  |  | Dundalk  |  |   | 6745 Roberts Ave.  |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |   |  |  |  |
| First Middle Last   |  |  | First Middle Last  |  |  |  |  |   |  |  |  |
| Raymond   |  |  | Wilby  |  |  | Anna L. Hand   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT (Husband) Address  |  |   |  |  |  |
| No  |  |  | 219-12-8586  |  |  | Mr. James H. Crouse, 6745 Roberts Ave.   |  |   | Dundalk, Md.   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Recurrent Adenocarcinoma Rectum</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Primary CA Rectum</i> |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Recent Profuse Hemorrhage from CA. mass. Perineum</i>  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1965, to Feb. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <i>M. J. Jaworski M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  |  |  |  | 22c. DATE SIGNED 2/12/68                      |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Melvin J. Jaworski M.D.  |  |  |  |  |  |  |  | 22e. ADDRESS 2711 Eastern Ave. Baltimore, Md. |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |   | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Burial  |  |  | 2/14/68  |  |  | Baltimore National Cem.  |  |   | Baltimore Md.  |  |  |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE FEB 14 1968   |  |   | 25b. REGISTRAR'S SIGNATURE   |  |  |

03154

03154

001 001 100

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
|--|--|---------|--|------------------|--|---|---------------------------------|--|--|--|------------------|------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| CERTIFICATE OF DEATH   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 02155  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 02144  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |         | First Middle Last  |                  |  | 2a. DATE OF DEATH   |                                 |  | 2b. HOUR   |  |                  |                        |  |  |
| John or GIOVANNI DALLATEZZA  |  |         |  |                  |  | 2 Month 19 Day 68 Year  |                                 |  | 11 40 PM   |  |                  |                        |  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH |  |   | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |                        |  |  |
| Male   |  | White   |  | 11-29-90         |  |   | 77 YRS.                         |  | MONTHS DAYS  |  | HOURS MIN.       |                        |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | 9. COUNTY OF DEATH   |  |                  |                        |  |  |
| Italy  |  |         | U.S.A.   |                  |  |   |                                 |  | Baltimore-RANDALLSTOWN   |  |                  | Md.                    |  |  |
| 10. CITY OR TOWN OF DEATH  |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                  |                        |  |  |
| Randallstown Md.   |  |         | Baltimore County   |                  |  | TILE SETTER   |                                 |  |  |  |                  |                        |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |         | 13b. COUNTY  |                  |  | 13c. CITY OR TOWN   |                                 |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  | 13e. STREET AND NUMBER |  |  |
| Md.  |  |         | BALTO  |                  |  | Baltimore   |                                 |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |                  | 205 S. Ext. St. Balb.  |  |  |
| 14. FATHER'S NAME  |  |         | 15. MOTHER'S MAIDEN NAME   |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| First Middle Last  |  |         | First Middle Last  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| Anthony DALLATEZZA   |  |         | GIUSEPPINA GRANAISE  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |         | 16b. SOCIAL SECURITY NO.   |                  |  | 17. INFORMANT   |                                 |  | Address  |  |                  |                        |  |  |
| No   |  |         | 131-01-8296  |                  |  | Chas + Mrs. ANGELA DALLATEZZA   |                                 |  |  |  |                  |                        |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| IMMEDIATE CAUSE (a) 4129 GANGLRENE OF INTESTINE  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) MESENTERIC THROMBOSES   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC HEART DISEASE  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 4200 Terminal ASPIRATION   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 19a. DATE OF OPERATION   |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                     |  |                  |                        |  |  |
| 2-19-68  |  |         | MESENTERIC THROMBOSES  |                  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 |  | YES  |  |                  |                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |         | 21b. TIME OF INJURY  |                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                 |  |  |  |                  |                        |  |  |
|  |  |         | HOUR A.M. Month Day Year   |                  |  |   |                                 |  |  |  |                  |                        |  |  |
|  |  |         | P.M. 19  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                 |  |  |  |                  |                        |  |  |
|  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-19-1968, to 2-19-1968, that (I) (we) last saw the deceased alive on 2-19-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 22b. SIGNATURE   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| Jose C. Laredo, MD. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 22c. DATE SIGNED   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 2-19-68  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |         | 22e. ADDRESS   |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| JOSE C. LAREDO   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |         | 23b. DATE  |                  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                 |  | 23d. LOCATION (City or Town) (County) (State)  |  |                  |                        |  |  |
| BURIAL   |  |         | FEB. 24/68   |                  |  | LORDON PARK   |                                 |  | BALTO - Md.  |  |                  |                        |  |  |
| 24. FUNERAL DIRECTOR   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| Frank Dally Neco 322 S. High St.   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 25a. REC'D BY REGISTRAR  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| FEB 23 1968  |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| 25b. REGISTRAR'S SIGNATURE   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |
| F. L. Neco   |  |         |  |                  |  |   |                                 |  |  |  |                  |                        |  |  |

02153

02144

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

| 02156  |  |                               |  |  |  |                                      |  |  |  | 02145  |  |                                |  |  |   |  |  |  |  |
|--|--|-------------------------------|--|--|--|--------------------------------------|--|--|--|--|--|--------------------------------|--|--|---|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |                               |  |  |  |                                      |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |                                |  |  |   |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>   |  |                               |  |  | c. LENGTH OF STAY IN 1b <u>10 yrs</u>  |                                      |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale-</u>  |  |                                |  |  |   |  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1405 Spring Ave.</u>   |  |                               |  |  | d. STREET ADDRESS <u>1405 Spring Ave.</u>  |                                      |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                |  |  |   |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Harold S. Daniels Sr.</u>   |  |                               |  |  | 4. DATE OF DEATH <u>Feb 23, 1968</u>   |                                      |  |  |  |  |  |                                |  |  |   |  |  |  |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Jan 16, 1913</u> |  | 9. AGE (In years last birthday) <u>55</u> yrs. |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HRS.<br>Hours Min. |  |  |   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elec. Truck Repair</u>  |  |                               |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Beth. Steel</u>   |                                      |  |  |  | 11. BIRTHPLACE (State or foreign country) <u>Delaware</u>  |  |                                |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                             |  |  |  |  |
| 13. FATHER'S NAME <u>Edward T. Daniels</u>   |  |                               |  |  | 14. MOTHER'S MAIDEN NAME <u>LNA. M. Sherwood</u>   |                                      |  |  |  |  |  |                                |  |  |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |  |                               |  |  | 16. SOCIAL SECURITY NO. <u>221-03-3831</u>   |                                      |  |  |  | 17. INFORMANT <u>Emma E. Daniels</u> Address <u>1405 Spring Ave.</u>   |  |                                |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4109 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Coronary Artery Disease</u><br>DUE TO<br>(c) _____ |  |                               |  |  |  |                                      |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |                                |  |  |   |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>  |  |                               |  |  |  |                                      |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                |  |  |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |  |  |  |                                      |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                                |  |  |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |  |                               |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                                      |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |                                |  |  | 20f. (City or town) (County) (State)                                |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1966</u> to <u>FEB 1968</u> , that (I) <del>was</del> last saw the deceased alive on <u>FEB 20 1968</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.   |  |                               |  |  |  |                                      |  |  |  |  |  |                                |  |  |   |  |  |  |  |
| 22a. SIGNATURE <u>John G. Orth, M.D.</u>   |  |                               |  |  |  |                                      |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  |                                |  |  | 22b. DATE SIGNED <u>2/25/68</u>                                     |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>John G. Orth, M.D.</u>   |  |                               |  |  |  |                                      |  |  |  | 22d. ADDRESS <u>8019 Philadelphia Road 21237</u>   |  |                                |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                               |  |  | 23b. DATE THEREOF <u>Feb 26 1968</u>   |                                      |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Catholics of Faith Cemetery</u>  |  |                                |  |  | 23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Cruch</u> ADDRESS <u>1211 Ches Ace Ave.</u>  |  |                               |  |  |  |                                      |  |  |  | 25a. REC'D BY REGISTRAR <u>FEB 27 1968</u>   |  |                                |  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                     |  |  |  |  |

02130

CERTIFICATE OF DEATH

02130

MAILED  
JAN 19 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02157</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02146</div>  |  |  |  |  |                                      |  |  |  |   |  |                             |
|--|--|--|--|--|--------------------------------------|--|--|--|---|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) <b>LAWRENCE R. DAWLEY</b>   |  |  |  |  |                                      | 2a. DATE OF DEATH <b>FEB 25</b> Month <b>1968</b> Day <b>1968</b> Year   |  |  | 2b. HOUR <b>5 A.</b> M.                           |  |                             |
| 3. SEX <b>M</b>  |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH <b>AUG. 11, 1895</b>  |                                      |  | 6. AGE (In years last birthday) <b>72</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS                       |  | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |  |  |   |  |                             |
| 10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6601 RANNOCH DRIVE</b> |  |                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>COTTER</b>                                  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b> |  |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  |  | 13b. COUNTY <b>BALTO.</b>  |  | 13c. CITY OR TOWN <b>CATONSVILLE</b> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>6601 Rannoch drive</b>  |  |                             |
| 14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>DAWLEY</b> Last <b>DAWLEY</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>CATHERINE</b> Middle <b>E.</b> Last <b>BROWN</b>   |                                      |  |  |  |   |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO. <b>214-01-4976</b>  |                                      | 17. INFORMANT <b>Ann Myr Weber - 6601 Rannoch</b>  |  |  |   | Address <b>RANNOCH</b>                                       |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute cardiac dilatation</b><br><b>428X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Chronic myocarditis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Senility</b> |  |  |  |  |                                      |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24/26</b> |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4222</b>   |  |  |  |  |                                      |  |  |  |   |  |                             |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |                                      | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                      |  |  |  |   |  |                             |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                      |  |  |  |   |  |                             |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>2/12/68</b> , 19 <b>68</b> , to <b>2/25/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/23</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |                                      |  |  |  |   |  |                             |
| 22b. SIGNATURE <b>A. Calais</b>  |  |  |  |  |                                      | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <b>2/27/68</b>                                      |   |  |                             |
| 22d. PHYSICIAN'S NAME (Type) <b>A. CALAIS</b>  |  |  |  |  |                                      | 22e. ADDRESS <b>6611 Frederick Ave</b>   |  |  |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>2-28-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>   |                                      | 23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>md.</b> (State)  |  |  |   |  |                             |
| 24. FUNERAL DIRECTOR <b>Farley Caravage F.N. Caton</b>   |  |  |  |  |                                      | ADDRESS  |  | 25a. REC'D BY REGISTRAR <b>DATE FEB 29 1968</b>                      |   | 25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>       |                             |

0315

ENTRANCE BY STAIR

0315

DATE: 11/11/11  
TIME: 11:11 AM  
BY: [illegible]  
RE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |  |                                   |  |  |
|--|--|--|--|--|---|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |                                   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  | 2b. HOUR                          |  |  |
| Joseph Harrison Debaugh  |  |  |  |  |   | Feb. Month 2, Year 1968   |  | M                                 |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |  |  |
| Male   |  | White  |  | July 4, 1898   |   | 69 YRS.   |  | MONTHS DAYS HOURS MIN.            |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                                   |  |  |
| Baltic Co., Md.  |  | U.S.A.   |  |  |   | Baltimore Md.   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Towson, Md.  |  |  | 419 Woodbine Ave. Towson   |  |   | Service Salesman  |  | Ashley Chev.                      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER   |  |
| Md.  |  |  | Baltimore  |  | Towson  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                   | 419 Woodbine Ave.,   |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |                                   |  |  |
| Franklin Debaugh   |  |  | Lenora Gray  |  |   |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   | Address  |                                   |  |  |
| NO   |  |  | None   |  | Mrs. Agnes T. Debaugh   |   | Towson, Md. 419 Woodbine Ave.  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Sclerosis</u><br>4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Two weeks</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201</u>  |  |  |  |  |   |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
|  |  |  |  |  |   |   |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |                                   |  |  |
|  |  |  |  |  |   |   |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |  | County State                      |  |  |
|  |  |  |  |  |   |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1953 to Jan 29, 1968, that (I) (we) last saw the deceased alive on Jan 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |   |   |  |                                   |  |  |
| 22b. SIGNATURE<br><u>Emmett L. Green</u>   |  |  |  |  |   | 22c. DATE SIGNED<br><u>2/2/68</u>   |  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Bon Secours Hosp</u>  |  |  |  |  |   | 22e. ADDRESS<br><u>2025 W. Fayette St - Baltimore 23</u>                                |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| Burial   |  | Feb. 5, 1968   |  | New Cathedral Cemetery   |   | Baltimore Md.   |  |                                   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |  |                                   |  |  |
| Frank H. Newell, Pikesville, Md.   |  |  |  | DATE FEB 7 1968  |   | Charles Judge   |  |                                   |  |  |

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|  |  |  |  |   |  |   |  |                        |  |                  |  |
|--|--|--|--|---|--|---|--|------------------------|--|------------------|--|
| 02159  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 02148   |  |                        |  |                  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH      |  | 2b. HOUR         |  |
| Clarence   |  | Evans  |  | Dedmon  |  |   |  | February               |  | 11:05            |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)                                      |  | IF UNDER 1 YEAR        |  | IF UNDER 24 HRS. |  |
| male   |  | white  |  | Nov. 12, 1897   |  | 70  |  | MONTHS                 |  | HOURS            |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                        |  |                  |  |
| North Carolina   |  | S.   |  |   |  | Baltimore   |  |                        |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)                                    |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |  |                        |  |                  |  |
| Catonsville  |  | SPRING GROVE STATE HOSP.   |  | engineer  |  | Army Eng. Corp  |  |                        |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER |  |                  |  |
| Md.  |  | Pr. Geo.   |  | Berwyn  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>     |  | 8605 - 63rd Avenue     |  |                  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                        |  |                  |  |
| Albert   |  | J. Dedmon  |  | Jean Louiza   |  | Irvin   |  |                        |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address   |  |                        |  |                  |  |
| yes  |  | 289-01-0936  |  | Records: SPRING GROVE STATE HOSPITAL  |  |   |  |                        |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |  | 485X   |  | Bronchopneumonia  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                         |  |                        |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  | (b)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |   |  |                        |  |                  |  |
| Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.  |  | (c)  |  |   |  |   |  |                        |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  | 491X   |  |   |  |   |  |                        |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                        |  |                  |  |
|  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |                        |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |                        |  |                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |                        |  |                  |  |
|  |  |  |  |   |  |   |  |                        |  |                  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from Dec. 25, 1967, to Feb. 5, 1968, that (X) (we) lost<br>saw the deceased alive on Feb. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                        |  |                  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |   |  |   |  |                        |  |                  |  |
| Anthony J. Young, M.D.   |  | 2-5-68   |  |   |  |   |  |                        |  |                  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  | 22e. ADDRESS   |  |   |  |   |  |                        |  |                  |  |
| Anthony J. Young, M.D.   |  | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228   |  |   |  |   |  |                        |  |                  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)                           |  |                        |  |                  |  |
| burial   |  | 2/8/68   |  | Green Hill Cemetery   |  | Waynesboro, Pennsylvania  |  |                        |  |                  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. RECD BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                        |  |                  |  |
| The S. H. Hines Co   |  | 2901-14th St. N.W.   |  | FEB 9 1968  |  |   |  |                        |  |                  |  |

05134

CERTIFICATE OF DEATH

05134

NAME

RESIDENCE

DATE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BY

DATE

SIGNATURE

DATE

REGISTRATION NO.

OFFICIAL USE

REMARKS

DATE

SIGNATURE

REMARKS

DATE

REMARKS

DATE

REMARKS

DATE

REMARKS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| JACOB  |  |  | DEITZ  |  |  | FEBRUARY 7, 1968   |  |  | 7:30 AM  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)  |  |  |
| MALE   |  |  | WHITE  |  |  |  |  |  | 87 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |  |
| LITHUANIA  |  |  | U.S.A.   |  |  |  |  |  | BALTIMORE Md.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| PIKESVILLE   |  |  | MILFORD MANOR NURSING HOME   |  |  | MERCHANT   |  |  | RETAIL   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| MARYLAND   |  |  | BALTIMORE  |  |  | PIKESVILLE   |  |  | 3506 OLD POST DRIVE #21208   |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |  |
| LOUIS DEITZ  |  |  | ?  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT Address  |  |  |  |  |  |
| NO   |  |  |  |  |  | MR. VICTOR DEITZ, 3506 OLD POST DRIVE #21208   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Cardio-Respiratory Failure   |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure  |  |  |  |  |  |  |  |  |  |  |  |
| (b) Arteriosclerotic CVHD  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Prostate - metastasis  |  |  |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |
| 4200   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 3, 1967, to FEB 7, 1968, that (I) (we) last saw the deceased alive on FEB 7, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED                             |  |
| DR. WILLARD APPLEFELD  |  |  |  |  |  |  |  |  |  | 2/7/68                                       |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS                                 |  |
|  |  |  |  |  |  |  |  |  |  | 5501 Park Heights Dr.                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| BURIAL   |  |  | 2-8-68   |  |  | BNAI ISRAEL  |  |  | BALTIMORE, MARYLAND  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD   |  |  |  |  |  | FEB 9 1968   |  |  |  |  |  |

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

02130

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> <span>02161</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02150</span> </div> <div style="text-align: center;">           DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|--------------------------|--|--|--------------------------|--|--|--------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>Werner   |  |  | Middle<br>Otto  |  |  | Last<br>DIRKS  |  |  | 2a. DATE OF DEATH<br>Month<br>2                           |  |  | Day<br>2                 |  |  | Year<br>68               |  |  | 2b. HOUR<br>8:00 <sup>am</sup> |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>5/1/34  |  |  | 6. AGE (In years<br>lost birthday)<br>33 YRS.                                  |  |  | IF UNDER 1 YEAR<br>MONTHS                                 |  |  | IF UNDER 24 HRS.<br>DAYS |  |  | IF UNDER 1 YEAR<br>HOURS |  |  | IF UNDER 24 HRS.<br>MIN.       |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore  |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Rosewood St. Hosp. |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Dependent   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>none                                   |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md.   |  |  | 13b. CITY OR TOWN<br>Seat Pleasant  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 13e. STREET AND NUMBER<br>6905 B Street  |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 14. FATHER'S NAME<br>Bernd Jansen   |  |  | 15. MOTHER'S MAIDEN NAME<br>Frances Christine   |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>no  |  |  | 16b. SOCIAL SECURITY NO.<br>none   |  |  | 17. INFORMANT<br>Rosewood Records, Owings Mills, Maryland |  |  |                          |  |  |                          |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Asphyxia<br>485x<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Aspiration of Stomach Contents<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last: 491x<br>(c) Orthostatic Bronchial Pneumonia<br>terminal<br>14 days<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>105% dehydration 31 yrs due to morbidism |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br>yes |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                       |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 9/1, 19 37, to 2/2, 19 68, that (X) (we) last<br>saw the deceased alive on 2/2, 19 68, and that in (X) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (X) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 22b. SIGNATURE<br>Richard A. Jones  |  |  | 22c. DATE SIGNED<br>2/5/68  |  |  | 22d. PHYSICIAN'S<br>NAME (Type)<br>Richard A. Jones, M.D.   |  |  | 22e. ADDRESS<br>Rosewood St. Hosp., Owings Mills, Md.                          |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>2/7/68   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rosewood Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Owings Mills, Md.             |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br>J. F. Eline & Sons  |  |  | 24a. REC'D BY REGISTRAR<br>DATE FEB 9 1968  |  |  | 24b. REGISTRAR'S SIGNATURE<br>Charles Jones   |  |  |  |  |  |   |  |  |                          |  |  |                          |  |  |                                |  |  |

05150

CENTRAL TO DEATH

05161

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

10/15/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02162  |  |  |  |  |  |  |  |  |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |  |  |  |                                |  |  |  |  | 02151 |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|---|---|--|--|--|--|--------------------------------|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Last  |  |  |  |   | 2a. DATE OF DEATH   |  |  |  |  | 2b. HOUR                       |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| Patricia Lynn Doyle  |  |  |  |  |  |  |  |  |   | 2 Month Day 4 Year 68   |  |  |  |  | 8:30 <sup>am</sup>             |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>3/7/57   |  |  | 6. AGE (In years last birthday)<br>10 YRS.  |   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Rosewood St. Hosp. |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Dependent   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>none   |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Catonsville   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |   |  | 13e. STREET AND NUMBER<br>1808 Alto Vista Avenue |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>William Edward Doyle   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Martha Ermin Rawleigh |  |  |  |   |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>no  |  |  | (If yes give war or dates of service)<br>---   |  |  | 16b. SOCIAL SECURITY NO.<br>none   |  |  | 17. INFORMANT<br>Mr. William Doyle, 1808 Alto Vista Ave, Catonsville, Md.<br><del>Rosewood Records, Owings Mills, Maryland, Md.</del> |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Orthostatic bronchial pneumonia</u><br>485X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>491X</u><br>(b) <u>Aspiration of stomach contents</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Aspiration of stomach contents</u> |  |  |  |  |  |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>14 days</u><br><u>14 days</u> |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Profound mental retardation + Microcephaly</u> <u>11 yrs</u>   |  |  |  |  |  |  |  |  |   |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>yes  |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>68</u> , to <u>2/4</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>2/4</u> , 19 <u>68</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |   |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Richard A. Jones</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |   |   |  |  | 22c. DATE SIGNED<br>2/5/68   |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Richard A. Jones, M.D.   |  |  | 22e. ADDRESS<br>Rosewood St. Hosp., Owings Mills, Md.  |  |  |  |  |  |   |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>2-7-68  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Balto. Md.   |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Witzke Funeral Directors, Balto., Md. 21229  |  |  | 4101 Edmondson Avenue  |  |  | 25a. REC'D BY REGISTRAR<br>FEB 7 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |   |  |  |  |  |                                |  |  |  |  |       |  |  |  |  |  |  |  |  |  |

Sales

22130



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

90  
30  
4

| <div>02163</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02152</div>   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                    |  |  |      |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|--------------------|--|--|------|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>VHERIS  |  |  | Middle  |  |  | Last<br>DRUCKER   |  |  | 2a. DATE OF DEATH<br>Month<br>FEBRUARY   |  |  | Day<br>2  |  |  | Yegr<br>1968  |  |  | 2b. HOUR<br>2 A M   |  |  |                    |  |  |      |  |  |
| 3. SEX<br>FEMALE  |  |  | 4. RACE<br>WHITE   |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (In years<br>last birthday)<br>83 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS  |  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN  |  |  |   |  |  |   |  |  |                    |  |  |      |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>NEW ORLEANS, LA.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                     |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>BALTIMORE   |  |  | 10. CITY OR TOWN OF DEATH<br>BALTIMORE   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>PROFESSIONAL HOUSE                                 |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>AT HOME                         |  |  |                    |  |  |      |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>BALTIMORE                                   |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>6309 WIRT AVENUE   |  |  | 14. FATHER'S NAME<br>First<br>SIMON   |  |  | Middle<br>HABER   |  |  | Last<br>JOSEPHINE   |  |  | Middle<br>BENSADEN |  |  | Last |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.                                   |  |  | 17. INFORMANT<br>MR. LAWRENCE GOLDBLOOM, 6309 WIRT AVE. #21215  |  |  | Address   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Coronary arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>10 yrs</u> |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>connect.</u>  |  |  |   |  |  |   |  |  |                    |  |  |      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201</u>   |  |  |  |  |  |   |  |  |   |  |  | 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |  |                    |  |  |      |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19 |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  | 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |                    |  |  |      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-17</u> , 19 <u>58</u> , to <u>2-2</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>1-29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  | 22b. SIGNATURE<br><u>Irvin Sauber</u> M.D.<br>DEGREE   |  |  | ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><u>2-4-68</u>   |  |  |   |  |  |                    |  |  |      |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <u>IRVIN SAUBER</u>   |  |  | 22e. ADDRESS<br><u>6505 Park Heights</u>                   |  |  | 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL  |  |  | 23b. DATE<br><u>2-4-68</u>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ELKVIEW MASONIC  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>CLARKSBURG, WEST VIRGINIA  |  |  |   |  |  |   |  |  |                    |  |  |      |  |  |
| 24. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  |  |  |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 6 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |  |   |  |  |   |  |  |   |  |  |                    |  |  |      |  |  |

05167

52136

# FOR STATE HEALTH DEPT

Any delay in filing this certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02164

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02153

|   |  |                 |                 |   |  |   |  |  |               |                               |  |  |  |  |                           |   |  |  |  |
|---|--|-----------------|-----------------|---|--|---|--|--|---------------|-------------------------------|--|--|--|--|---------------------------|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |  |                 | First<br>CLAIRE |   |  | Middle<br>MARIE   |  |  | Last<br>DUFFY |                               |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br>Feb 29 1968                             |  |  | 2b. HOUR<br>P. M.<br>9:30 |   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Cau. |                 | 5. DATE OF BIRTH<br>Dec. 30, 1959   |  | 6. AGE (in years last birthday)<br>8 YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |               | IF UNDER 24 HRS<br>HOURS MIN. |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>Feb 29 1968                            |  |  | 2d. HOUR<br>P. M.<br>9:30 |   |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>New Jersey   |  |                 |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               |                               |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.  |  |  |                           |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |                 |                 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Student   |               |                               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                           |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |                 |                 | 13b. COUNTY<br>Baltimore  |  |   |  | 13c. CITY OR TOWN<br>Cockeysville  |               |                               |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |                           | 13e. STREET AND NUMBER<br>10515 York Ave. |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Charles J. Duffy  |  |                 |                 |   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Elizabeth Malarkey |  |  |               |                               |  |  |  |  |                           |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |  |                 |                 | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)                                   |  |   |  | 17. INFORMANT<br>Charles J. Duffy, Same as # 13  |               |                               |  |  |  |  |                           |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Severe Shock, due to exanguinating intre-abdominal hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>al hemorrhage<br>(b) <u>Rupture of liver, both kidneys and right lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Laceration of inferior vena cava</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>814.7</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><u>812.4</u> |  |                 |                 |   |  |   |  |  |               |                               |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                           |   |  |  |  |
| 19a. DATE OF OPERATION<br>Feb 29 1968   |  |                 |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>MULTIPLE INJURIES                              |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |               |                               |  |  |  |  |                           |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |                 |                 | 21b. TIME OF INJURY Month, Day, Year<br>HOUR:MIN<br>5:45 P.M. 2/29 1968                             |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Hit by Automobile   |               |                               |  |  |  |  |                           |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                 |                 | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>STREET              |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>WARREN RD. COCKEYSVILLE BALTO. MD.   |               |                               |  |  |  |  |                           |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>   |  |                 |                 |   |  |   |  |  |               |                               |  |  |  |  |                           |   |  |  |  |
| ACTUAL SIGNATURE<br>William A. Pillsbury  |  |                 |                 | M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | 22b. DATE SIGNED<br>3-1-68   |               |                               |  |  |  |  |                           |   |  |  |  |
| EXAMINER'S NAME (Type)<br>William A. Pillsbury  |  |                 |                 | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |               |                               |  |  |  |  |                           |   |  |  |  |
| ADDRESS (Street, P.O., town, or county)<br>Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204  |  |                 |                 | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |   |  | 23b. DATE<br>Mar. 4, 1968  |               |                               |  |  |  |  |                           |   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney Valley Cemetery   |  |                 |                 | 23d. LOCATION (City or Town) (County) (State)<br>Cockeysville, Maryland                             |  |   |  |  |               |                               |  |  |  |  |                           |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204   |  |                 |                 | 25a. REC'D BY REGISTRAR<br>MAR 4 1968   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John Judge   |               |                               |  |  |  |  |                           |   |  |  |  |

42150

40130

100

•

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film G398

3/4/68 ap

02165

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02154

|  |         |  |                  |  |                                  |   |   |                        |  |
|--|---------|--|------------------|--|----------------------------------|---|---|------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |         | First  | Middle           | Last   | 2a. DATE OF DEATH                |   | 2b. HOUR  |                        |  |
| Louis DUNGAN   |         |  |                  |  | Month - 2 - Day - 24 - Year - 68 |   | 6 P. M.   |                        |  |
| 3. SEX   | 4. RACE |  | 5. DATE OF BIRTH |  | 6. AGE (In years lost birthday)  |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |                        |  |
| M  | W       |  | Sept. 23, 1879   |  | 79 88 YRS.                       |   |   |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. COUNTY OF DEATH  |   |                        |  |
| Baltimore, Md.   |         |  |                  |  |                                  | Baltimore Md.   |   |                        |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                                  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |                        |  |
| Holbrook   |         | CHAPEL HILL N.H.   |                  | Retired - Civil Service  |                                  |   |   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |                  | 13c. CITY OR TOWN  |                                  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER |  |
| Maryland   |         | Baltimore  |                  | Holbrook   |                                  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |   | Chapel Hill N. H.      |  |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |                                  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address  |  |
| Stevenson  |         | Archer Dungan  |                  |  |                                  |   |   | Mr. Carl Heinmiller    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) 4201   |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |                  |  |                                  |   |   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         | Generalized Arteriosclerosis - Senility                                      |                  |  |                                  |   |   |                        |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                  |   |   |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                  |   |   |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-25-, 1965, to 2-24-, 1968, that (I) (we) last saw the deceased alive on 2-24-, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |                  |  |                                  |   |   |                        |  |
| 22b. SIGNATURE Cesar Valle Caverio   |         | 22c. DATE SIGNED 2-24-68   |                  | 22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERO  |                                  | 22e. ADDRESS 8624 Liberty Rd  |   |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE 2/27/68  |                  | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery  |                                  | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md.                      |   |                        |  |
| 24. FUNERAL DIRECTOR Wm. F. T. ...   |         | ADDRESS Baltimore, Md.   |                  | 25a. REC'D BY REGISTRAR DATE FEB 29 1968   |                                  | 25b. REGISTRAR'S SIGNATURE Charles Judge  |   |                        |  |

45136

23180



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |  |  |        |  |                          |  |          |  |                  |
|---|--|--|--------|--|--------------------------|--|----------|--|------------------|
| 02166   |  | 02155  |        |  |                          |  |          |  |                  |
| 1. DECEASED-NAME (Type or print)  |  | First  | Middle | Last   | 2a. DATE OF DEATH        |  | 2b. HOUR |  |                  |
| THOMAS  |  | E.   | DUNMAN |  | Month                    | Day  | Year     | 3:15 PM                                      |                  |
| FEBRUARY  |  | 6  |        | 1968   |                          |  |          |  |                  |
| 3. SEX  |  | 4. RACE  |        | 5. DATE OF BIRTH   |                          | 6. AGE (In years last birthday)  |          | IF UNDER 1 YEAR                              | IF UNDER 24 HRS. |
| MALE  |  | WHITE  |        | 8/19/12  |                          | 55   |          | MONTHS                                       | DAYS             |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                          | 9. COUNTY OF DEATH   |          | Md.  |                  |
| VIRGINIA  |  | U.S.A.   |        | BALTIMORE COUNTY   |                          |  |          |  |                  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |          |  |                  |
| FORT HOWARD   |  | VET. ADM. HOSPITAL   |        | CARPENTER  |                          | CONSTRUCTION   |          |  |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |          | 13e. STREET AND NUMBER                       |                  |
| MARYLAND  |  | ANNE ARUNDEL   |        | PASADENA   |                          | BOX 95, Route 10   |          |  |                  |
| 14. FATHER'S NAME   |  | First  | Middle | Last   | 15. MOTHER'S MAIDEN NAME |  | First    | Middle                                       | Last             |
| WILLIS W. DUNMAN  |  |  |        |  | LULA M. WATTS            |  |          |  |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT  |                          | Address  |          |  |                  |
| YES WW II   |  | 225 10 67 23   |        | CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.   |                          |  |          |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |        |  |                          |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |        |  |                          |  |          | MINUTES                                      |                  |
| IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION   |  |  |        |  |                          |  |          |  |                  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |  |        |  |                          |  |          |  |                  |
| (b) CORONARY OCCLUSION  |  |  |        |  |                          |  |          |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |        |  |                          |  |          |  |                  |
| (c)   |  |  |        |  |                          |  |          |  |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |        |  |                          |  |          |  |                  |
| 4201  |  |  |        |  |                          |  |          |  |                  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |          |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                          |  |          |  |                  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                          |  |          |  |                  |
| 22a. I certify that (X) (this hospital) attended the deceased from 1/31/68, 19__, to 2/6/68, 19__, that (X) (we) last saw the deceased alive on 2/6/68, 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |        |  |                          |  |          |  |                  |
| 22b. SIGNATURE  |  |  |        |  |                          |  |          | 22c. DATE SIGNED                             |                  |
| KRISHNA V. S. RAO, M. D.  |  |  |        |  |                          |  |          | 2/7/68                                       |                  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |        |  |                          |  |          | 22e. ADDRESS                                 |                  |
| VAH FORT HOWARD, MARYLAND   |  |  |        |  |                          |  |          |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION (City or Town) (County) (State)  |          |  |                  |
| BURIAL  |  |  |        | MEADOWRIDGE CEMETERY   |                          | GLEN BURNIE, MD.   |          |  |                  |
| 24. FUNERAL DIRECTOR  |  | 25a. RECEIVED BY REGISTRAR   |        | 25b. REGISTRAR'S SIGNATURE   |                          |  |          |  |                  |
| C.B. Fleming  |  | DATE   |        | 8 1968   |                          |  |          |  |                  |
| 200 CRATIN HIGHWAY, GLEN BURNIE, MD.  |  |  |        |  |                          |  |          |  |                  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |   |   |   |  |   |  |   |
|--|--|---|---|---|--|---|--|---|
| 02167  |  | 02156   |   |   |  |   |  |   |
| 1. DECEASED-NAME (Type or print) <b>CHARA A. DUNNIGAN-DONEGAN-DUNEGAN</b>  |  | 2a. DATE OF DEATH<br>Month <b>8</b> - Day <b>11</b> - Year <b>68</b>  |   | 2b. HOUR<br><b>6:25 M</b>   |  |   |  |   |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>                              | 5. DATE OF BIRTH<br><b>OCT. 28, 1880</b>  |   | 6. AGE (In years last birthday)<br><b>87</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                    | IF UNDER 24 HRS.<br>HOURS<br>MIN.   |  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>PENNA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> Md. |   |  |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>OVERLEA</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>119 WEST ELM AVE.</b>  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                   |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>OVERLEA</b>               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 | 13e. STREET AND NUMBER<br><b>119 WEST ELM AVENUE</b> |   |  |   |
| 14. FATHER'S NAME<br>First <b>JOSEPH</b> Middle <b>MC CUSKER</b> Last <b>MARY</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>MARY</b> Middle <b>CREIG</b> Last <b>CREIG</b>   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)             |  |   | 16b. SOCIAL SECURITY NO.<br><b>WA 366922</b> | 17. INFORMANT<br><b>THERESA REZAC</b> Address<br><b>119 WEST ELM AVENUE</b> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Coronary Thrombosis</b><br><b>4109</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>?</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b> |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b>                         |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                  |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/9, 1968</b> , to <b>2/9, 1968</b> , that (I) (we) last saw the deceased alive on <b>2/9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |   |
| 22b. SIGNATURE<br><b>V. SADRANANDA M.D.</b>  |  | DEGREE<br><b>M.D.</b>   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/11/68</b>  |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>V. SADRANANDA</b>   |  | 22e. ADDRESS<br><b>6801 BELAIR ROAD BALTO MARYLAND</b>  |   |   |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2-15-1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL CEMETERY</b>   |  | 23d. LOCATION (City or Town) (County) (State) Md.<br><b>OLD FEDERICK RD BALTIMORE</b> |  |   |
| 24. FUNERAL DIRECTOR<br><b>THE DIAPEL BROTHERS</b>   |  | ADDRESS<br><b>710 BELAIR ROAD</b>   |   | 25a. REC'D BY REGISTRAR<br><b>FEB 15 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                      |  |   |

05151

05151

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 02168 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |                  |  |                 |      |  |      |   |   |  |  | 02157 |  |
|--|---------|------------------|--|-----------------|------|--|------|---|---|--|--|-------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         |                  | First Middle Last  |                 |      | 20. DATE KNOWN OF DEATH  |      |   | 2b. HOUR                                      |  |  |       |  |
| Mary Emma line EDWARDS   |         |                  |  |                 |      | Month Day Year   |      |   | 24 10 30 PM                                   |  |  |       |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR |      | IF UNDER 24 HRS  |      | 2c. DATE PRONOUNCED DEAD  |   | 2d. HOUR                                     |  |       |  |
| F  | W       | 3/18/85          | 82 YRS.  | MONTHS          | DAYS | HOURS  | MIN. | Month Day Year  | 24 11 30 PM                                   |  |  |       |  |
| 7a. BIRTHPLACE (State or foreign country)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                 |      | 8. MARRIED   |      |   | 9. COUNTY OF DEATH                            |  |  |       |  |
| Virginia   |         |                  | USA  |                 |      | NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   | Baltimore Md.                                 |  |  |       |  |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                 |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                              |      |   | 12b. KIND OF BUSINESS OR INDUSTRY             |  |  |       |  |
| Lansdowne  |         |                  | 164 Stafford St.   |                 |      | Housewife  |      |   | -   |  |  |       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                  | 13b. COUNTY  |                 |      | 13c. CITY OR TOWN  |      | 13d. INSIDE CITY LIMITS?  |   | 13e. STREET AND NUMBER                       |  |       |  |
| Md.  |         |                  | Balto.   |                 |      | Lansdowne  |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 164 Stafford St.                             |  |       |  |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME   |                 |      |  |      |   |   |  |  |       |  |
| First Middle Last  |         |                  | First Middle Last  |                 |      |  |      |   |   |  |  |       |  |
| Jerry P. Vass  |         |                  | Lucetta Webb   |                 |      |  |      |   |   |  |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)  |         |                  | 16b. SOCIAL SECURITY NO.   |                 |      | 17. INFORMANT  |      |   | ADDRESS                                       |  |  |       |  |
| No   |         |                  |  |                 |      | Mrs. Emma V. Morlock   |      |   | 5509 Alban Ave. #14                           |  |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                  |  |                 |      |  |      |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |       |  |
| PART 1. DEATH WAS CAUSED BY:   |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| IMMEDIATE CAUSE (a) Cardio-Vascular Disease  |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| 412.9 DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)  |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| 4221 Diabetes mellitus   |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                 |      | 20. AUTOPSY?   |      |   |   |  |  |       |  |
|  |         |                  |  |                 |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      |   |   |  |  |       |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>  |         |                  | 21b. TIME OF INJURY Month, Day, Year   |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                                      |      |   |   |  |  |       |  |
| CAUSE OF DEATH   |         |                  | HOUR A.M. P.M.   |                 |      | 19   |      |   |   |  |  |       |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                 |      | 21f. LOCATION Street or R.F.D. No. City or Town County State   |      |   |   |  |  |       |  |
|  |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                  |  |                 |      |  |      |   |   |  |  |       |  |
| ACTUAL SIGNATURE   |         |                  | James N. Frederick   |                 |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |      |   | 22b. DATE SIGNED                              |  |  |       |  |
| EXAMINER'S NAME (Type)   |         |                  | James N. Frederick   |                 |      | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |      |   | 2/2/68  |  |  |       |  |
|  |         |                  |  |                 |      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |      |   | 1311 Francis Ave                              |  |  |       |  |
|  |         |                  |  |                 |      | ADDRESS (Street, city, town, or county)  |      |   | Balto. Md 21222                               |  |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                  | 23b. DATE  |                 |      | 23c. NAME OF CEMETERY OR CREMATORY   |      |   | 23d. LOCATION (City or Town) (County) (State) |  |  |       |  |
| Burial   |         |                  | 2/6/68.  |                 |      | Cemetery Belair Memorial Hospital  |      |   | Baltimore, Md.                                |  |  |       |  |
| 24. FUNERAL DIRECTOR   |         |                  |  |                 |      | ADDRESS  |      |   | 25a. REC'D BY REGISTRAR                       |  |  |       |  |
| Leonard J. Ruck, Inc. Balto. Md. 21214   |         |                  |  |                 |      | 21214  |      |   | FEB 5 1968                                    |  |  |       |  |
|  |         |                  |  |                 |      | 25b. REGISTRAR'S SIGNATURE   |      |   | Charles Judge                                 |  |  |       |  |

02130

02130

ANDRE L. VANDERBILT, JR. (1910-1971)

1910-1971

1910

1910

1910

1910

1910-1971

1910

1910-1971



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 file 398 2-26-68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|  |  |   |  |  |   |   |  |  |  |  |  |
|--|--|---|--|--|---|---|--|--|--|--|--|
| 02169  |  |   | 02158  |  |   |   |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>TIMOTHY W. EDWARDS</b>   |  |   | 2a. DATE OF DEATH <b>FEB</b> Month <b>8</b> Day <b>1968</b> Year                                   |  |   | 2b. HOUR <b>M</b>   |  |  |  |  |  |
| 3. SEX <b>M</b>  |  | 4. RACE <b>W</b>                        |  | 5. DATE OF BIRTH <b>2/28/92</b>  |   | 6. AGE (In years last birthday) <b>75</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.              |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>VA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>BALTO.</b>  |  | Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>ESSEX</b>   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>362 LEEANNE RD</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>MARTIN CO</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>  |  |   | 13b. COUNTY <b>BALTO.</b>  |  | 13c. CITY OR TOWN <b>ESSEX</b>                      |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>362 LEEANNE RD</b>       |  |  |
| 14. FATHER'S NAME First Middle Last <b>TIMOTHY H. EDWARDS</b>  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last <b>?</b>  |  |   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>UNK</b> (If yes give war or dates of service)  |  |   | 16b. SOCIAL SECURITY NO. <b>215-10-3538</b>  |  | 17. INFORMANT <b>MAE EDWARDS</b>                    |   |  | Address <b>ABOVE</b>   |  |  |  |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>342X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Parkinson</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |   |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>350X</b>  |  |   |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)         |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                       |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19____, to <b>1968</b> , 19____, that (I) (we) last saw the deceased alive on <b>2-6</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE <b>Leopoldo Gross</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |   |  |  |   | 22c. DATE SIGNED <b>2-8-68</b>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Leopoldo Gross</b>   |  |   |  |  |   | 22e. ADDRESS  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  |   | 23b. DATE <b>2/10/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>MORELANDS</b> |   | 23d. LOCATION (City or Town) (County) (State) <b>BALTO. MD</b>                               |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>J.E. CONNELLY SONS 300 MACE</b>  |  |   |  |  |   | 25a. REC'D BY REGISTRAR <b>DATE FEB 13 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                      |  |  |  |

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

03163

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Roy</b>  |  | First <b>R.</b> Middle <b>England</b> Last <b>England</b>  |  | 2a. DATE OF DEATH<br>Month <b>Feb</b> Day <b>11</b> Year <b>1968</b>  |  | 2b. HOUR<br><b>8.25pm</b>   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>Oct 20, 1889</b>   |  | 6. AGE (In years last birthday)<br><b>78</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>rural Balto.</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6910 Digby Road</b>                                 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Sales Specialist</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Auto.</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Balto</b>   |  | 13c. CITY OR TOWN <b>rural Balto</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET AND NUMBER<br><b>6910 Digby Road</b> |  |
| 14. FATHER'S NAME First <b>Thomas</b> Middle <b>England</b> Last <b>England</b>   |  | 15. MOTHER'S MAIDEN NAME First <b>Henrietta</b> Middle <b>Knight</b> Last <b>Knight</b>  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>216-03-7133</b>   |  | 17. INFORMANT Address<br><b>Mrs Estelle England 6910 Digby Road</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the rectosigmoid</b><br>1541 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of the prostate</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>terminal uremia</b><br>154X<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>9 Mos</b><br><b>9 Mos</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>Hypertension - Asymptomatic cardiovascular disease</b>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>July 1967</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Above</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7-19</b> , 19 <b>67</b> , to <b>2-11</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>M Davis</b>  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-13-68</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Marvin Davis</b>   |  | 22e. ADDRESS<br><b>6512 Liberty Rd. Balto Md 21207</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/14/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville Balto Md</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Living Byers</b>   |  | ADDRESS<br><b>8728 Liberty Rd</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 16 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

02130

02130

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

Page 11 of 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02171  |  |  |  |  |  |  |  |  |  | 02168  |  |                             |  |  |                             |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|-----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH                            |  |                             |  |  |                             |  |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |  |  | Month Day Year                               |  |                             |  |  |                             |  |  |  |  |
| Marie Anna Engleberth  |  |  |  |  |  |  |  |  |  | 2 9 68 7:05P M                               |  |                             |  |  |                             |  |  |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| Female   |  |  | Cau  |  |  | 3-18-1895  |  |  | 72 YRS.  |  |  |                             |  |  |                             |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |  |                             |  |  |                             |  |  |  |  |
| Maryland   |  |  | U.S.A.   |  |  |  |  |  | Baltimore  |  |  |                             |  |  | Md.                         |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                             |  |  |                             |  |  |  |  |
| Baltimore  |  |  | Greater Baltimore Med. Center  |  |  | Housewife  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER      |  |  |                             |  |  |  |  |
| Maryland   |  |  | Baltimore  |  |  |  |  |  |  |  |  | Engelberth Ave              |  |  |                             |  |  |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| Harry Creamer  |  |  |  |  | Margaret Ott                               |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  | 16b. SOCIAL SECURITY NO.                   |  |  |  |  | 17. INFORMANT Address                        |  |                             |  |  |                             |  |  |  |  |
| No   |  |  |  |  |  |  |  |  |  | Mr William F Engelberth 111                  |  |                             |  |  | Same                        |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                             |  |  |                             |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarct   |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| 450X DUE TO, OR AS A CONSEQUENCE OF (b) Multiple pulmonary emboli  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 465X DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| Necrotizing pancreatitis   |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes                     |  |  |                             |  |  |                             |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/19, 1968, to 2/9/68, 1968, that (I) (we) last saw the deceased alive on 2/9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  | 22c. DATE SIGNED                           |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| R. Breitenacker, M.D.  |  |  |  |  | 6701 N. Charles Street                     |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS                               |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| R. Breitenacker, M.D.  |  |  |  |  | 6701 N. Charles Street                     |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |                             |  |  |                             |  |  |  |  |
| Burial   |  |  | 2/14/68  |  |  | Parkwood   |  |  | Baltimore Maryland   |  |  |                             |  |  |                             |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR DATE               |  |  |  |  | 25b. REGISTRAR'S SIGNATURE                   |  |                             |  |  |                             |  |  |  |  |
| Leonard J Ruck Inc 5305 Harford Rd   |  |  |  |  | FEB 13 1968                                |  |  |  |  |  |  |                             |  |  |                             |  |  |  |  |

03130

03130

1911

1911

1911

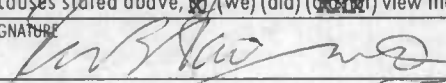
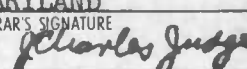
1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |  |   |   |   |  |
|--|--|---|---|---|--|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |  |   |   |   |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |   |   |   |  |
| 02172  |  |   |   |   |  |  |   | 02161   |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First Middle Last   |   |  | 2a. DATE OF DEATH<br>Month Day Year  |   | 2b. HOUR  |   |  |
| LEWIS (Louis) R.   |  |   | EPPS  |   |  | FEBRUARY 14 1968   |   | 12:45 PM  |   |  |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>lost birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN  |   |  |
| MALE   |  | NEGRO   |   | 3/4/16  |  | 51 YRS.  |   |   |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |   | Md.   |   |  |
| VIRGINIA   |  | U.S.A.  |   |   |  | BALTIMORE COUNTY   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |  |
| FORT HOWARD  |  |   | VET. ADM. HOSPITAL  |   |  | LABORER  |   | SCHOOL  |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE   |  |   | 13b. COUNTY   |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER                          |  |
| MARYLAND   |  |   |   |   | BALTIMORE  |  | YES   |   | 131 AISQUITTH STREET                            |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                   |   |  |  |   |   |   |  |
| RUFUS EPPS   |  |   | SUE BROWN   |   |  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address  |  |   |   |   |  |
| YES WW II  |  |   | 213 07 60 66  |   | CLIN. RECORDS, VA HOSPITAL, FT HOWARD MD.  |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1541<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) CARCINOMA OF RECTUM<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(c) DUE TO, OR AS A CONSEQUENCE OF |  |   |   |   |  |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>154x   |  |   |   |   |  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br>YES                  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.) |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |   | County State  |   |  |
| 22a. I certify that (a) (this hospital) attended the deceased from 12/20/67, 19__, to 2/14/68, 19__, that (b) (we) last<br>saw the deceased alive on 2/14/68, 19__, and that in (c) (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (d) (we) (did) (didn't) view the body after death.                 |  |   |   |   |  |  |   |   |   |  |
| 22b. SIGNATURE<br>  |  |   |   |   | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/15/68   |   |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type) KRISHNA V. S. RAO, M. D.   |  |   |   |   | 22e. ADDRESS<br>VAH FORT HOWARD, MARYLAND  |  |   |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |   |   |   |  |
| BURIAL   |  | 2-19-68   |   | BALTIMORE NATIONAL  |  | BALTIMORE, MARYLAND  |   |   |   |  |
| 24. FUNERAL DIRECTOR   |  |   |   | ADDRESS<br>MORTEN & DYETTE FUNERAL HOME<br>1701 Laurens St. Baltimore, Md.  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 16 1968  |   | 25b. REGISTRAR'S SIGNATURE<br> |   |  |

13130

REPUBLIC OF CHINA

87130

1974:06

REPUBLIC OF CHINA

DATE

1974 (1974) 06/01

11

11/11

11/11

11/11

REPUBLIC OF CHINA

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

REPUBLIC OF CHINA

11/11

11/11

REPUBLIC OF CHINA

11/11

11/11

11/11

11/11

11/11

11/11

11/11

11/11

REPUBLIC OF CHINA

11/11

REPUBLIC OF CHINA

11/11

REPUBLIC OF CHINA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-7-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |       |  |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
|--|--|-------|--|--|--|---|--|--|---|--|--|---|--|--|--------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |       |  |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| CERTIFICATE OF DEATH   |  |       |  |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| 02173  |  | 02162 |  |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |       | First<br>JAMES   |  |  | Middle<br>W.  |  |  | Last<br>FANNIN  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>FEBRUARY 14 1968 |  |  | 2b. HOUR<br>5:55AM             |  |  |
| 3. SEX<br>MALE   |  |       | 4. RACE<br>WHITE   |  |  | 5. DATE OF BIRTH<br>11/6/13 11/5/1912   |  |  | 6. AGE (In years last birthday)<br>55 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.               |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>KENTUCKY  |  |       | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>BALTIMORE COUNTY, Md.   |  |  |   |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD   |  |       | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VET. ADM. HOSPITAL |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>GRAVE DIGGER   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>CEMETERY   |  |  |   |  |  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |  |       | 13b. COUNTY<br>BALTIMORE   |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>822 W. Lombard Street         |  |  |                                |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>JAMES EDWARD FANNIN  |  |       | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>SALLIE CALLAHAN                                   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)<br>YES WW II   |  |       | 16b. SOCIAL SECURITY NO.<br>403 09 07 88   |  |  | 17. INFORMANT<br>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.   |  |  |   |  |  |   |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA, MASSIVE LUNG</u><br><u>481X</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>490X</u><br>(b) <u>CARCINOMA OF PROSTATE WITH METASTASIS TO SPINE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARTERIOSCLEROSIS, GENERALIZED</u> |  |       |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |       |  |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| 19a. DATE OF OPERATION   |  |       | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES                     |  |  |   |  |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |       | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |       | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                                |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>2/13/68</u> , 19 <u>  </u> , to <u>2/14/68</u> , 19 <u>  </u> , that (X) (we) last saw the deceased alive on <u>2/14/68</u> , 19 <u>  </u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.   |  |       |  |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| 22b. SIGNATURE<br><u>Ahmed Kutty M.D.</u>  |  |       | 22c. DATE SIGNED<br>2/14/68  |  |  | 22d. PHYSICIAN'S NAME (Type)<br>AHMED C. K. KUTTY, M. D.  |  |  |   |  |  |   |  |  |                                |  |  |
| 22e. ADDRESS<br>VAH FORT HOWARD, MARYLAND  |  |       |  |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  |       | 23b. DATE<br>2/16/1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |  |   |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br><u>John J. Cowan &amp; Son Inc.</u>  |  |       | ADDRESS<br>901 COWAN FUNERAL HOME  |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 16 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Jones</u>   |  |  |   |  |  |                                |  |  |
| 25c. HOLLINS & POPPLETON STS. BALTIMORE, MD.   |  |       | 23   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |

05163

05170

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
JAN 10 1917  
RECEIVED  
PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

FOR THE CHIEF, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

RECEIVED

RECEIVED  
JAN 10 1917  
PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
JAN 10 1917  
RECEIVED  
PLANT INDUSTRY  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02174   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02163  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| ROBERT ARNOLD FERBER  |  |  |  |  |  |  |  |  |  | FEBRUARY 5, 1968   |  |  |  |  |  |  |  |  |  | 9:30 M   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday)                                      |  |  |  |  |  |  |  |  |  |
| MALE  |  |  |  |  |  |  |  |  |  | WHITE  |  |  |  |  |  |  |  |  |  | AUGUST 7, 1918   |  |  |  |  |  |  |  |  |  | 49 YRS.  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |
| NEW JERSEY  |  |  |  |  |  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |  |  |  |  |  |  |
| TOWSON  |  |  |  |  |  |  |  |  |  | ST. JOSEPH HOSPITAL  |  |  |  |  |  |  |  |  |  | District manager   |  |  |  |  |  |  |  |  |  | U.S. STEEL   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |  |  |  |  |  |  |  |  | 13b. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13c. INSIDE CITY LIMITS?   |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER   |  |  |  |  |  |  |  |  |  |
| STATE MARYLAND  |  |  |  |  |  |  |  |  |  | COUNTY BALTIMORE   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 19 CROFTLEY RD. #21093   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Herman B. Ferber  |  |  |  |  |  |  |  |  |  | Buelah A. Smith  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |
| Yes   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Family records   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  | Gram negative bacteriemia  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | 455 X  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | 467 X  |  |  |  |  |  |  |  |  |  | (b) hemorrhoidectomy   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Acute suppurative prostatitis   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | HOUR A.M. Month Day Year   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | P.M. 19  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION  |  |  |  |  |  |  |  |  |  | City or Town   |  |  |  |  |  |  |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Street or R.F.D. No.   |  |  |  |  |  |  |  |  |  | County   |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | State  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from FEBRUARY 3, 1968, to February 5, 1968, that (we) last saw the deceased alive on FEBRUARY 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | DEGREE   |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | February 6, 1968   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Lawrence F. Misanik, M.D.   |  |  |  |  |  |  |  |  |  | 7620 York Rd., Towson, Md. 21204   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | Feb. 8, 1968   |  |  |  |  |  |  |  |  |  | Dulaney Valley Memorial  |  |  |  |  |  |  |  |  |  | Cockeysville, Md.  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | John Burns' Sons, Towson, Md.  |  |  |  |  |  |  |  |  |  | DATE 8 1968  |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |

02120

02120

02120

02120

02120



02120

02120

02120

02120

02120



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02175  |  |  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 02164   |  |   |  |  |  |                  |  |                            |  |  |  |
|--|--|--|--|--|--|---|--|---|--|---|--|--|--|------------------|--|----------------------------|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  | First Middle Last  |  |   |  | 2a. DATE OF DEATH   |  |   |  | 2b. HOUR   |  |                  |  |                            |  |  |  |
| Barbara P. Fink  |  |  |  |  |  |   |  | Month 2 Day 2 Year 68   |  |   |  | 10 A M   |  |                  |  |                            |  |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   |  | 6. AGE (In years last birthday)   |  |   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |  |                            |  |  |  |
| Female   |  | white  |  | 12/26/1873.7   |  |   |  | 94 YRS.   |  |   |  | MONTHS DAYS  |  | HOURS MIN        |  |                            |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED   |  | 9. COUNTY OF DEATH  |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| Consey Md.   |  | U.S.A.   |  | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | Baltimore   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY             |  |  |  |                  |  |                            |  |  |  |
| Lanersville Md.  |  | Forest Haven Nursing Home  |  |  |  | Housewife   |  |   |  | at Home                                       |  |  |  |                  |  |                            |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER  |  |   |  |  |  |                  |  |                            |  |  |  |
| Md.  |  |  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 1104 Washington Blvd.   |  |   |  |  |  |                  |  |                            |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| First Middle Last  |  |  |  | First Middle Last  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| Unknown  |  |  |  | Unknown  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address   |  |   |  |  |  |                  |  |                            |  |  |  |
| no   |  |  |  | 219-54-4201  |  | Forest Haven Nursing Home   |  | 315 Gude Ave  |  |   |  |  |  |                  |  |                            |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |                  |  |                            |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| IMMEDIATE CAUSE (a) 4129   |  |  |  |  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| (b) AMEOPD - 1815M010 ECAANIC  |  |  |  |  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| (c) UNSTABLE M0101   |  |  |  |  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| 4221   |  |  |  |  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?   |  |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                  |  |                            |  |  |  |
|  |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |  |  |  |                  |  |                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING   |  |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |  |  |  |                  |  |                            |  |  |  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |   |  | 21f. LOCATION   |  |   |  |  |  |                  |  |                            |  |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |   |  | Street or R.F.D. No. City or Town County State                                  |  |   |  |  |  |                  |  |                            |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 3/12, 1966, to 2/2, 1968, that (I) (we) lost saw the deceased alive on 2/2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |   |  |  |  |                  |  |                            |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |   |  |   |  |   |  | 22c. DATE SIGNED   |  |                  |  |                            |  |  |  |
| John H. Shaw, M.D.   |  |  |  |  |  |   |  |   |  |   |  | 2/1/68   |  |                  |  |                            |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |   |  |   |  |   |  | 22e. ADDRESS   |  |                  |  |                            |  |  |  |
|  |  |  |  |  |  |   |  |   |  |   |  | 5800 Edmondson Ave Balt 38, Md.                                      |  |                  |  |                            |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION (City or Town) (County) (State) |  |  |  |                  |  |                            |  |  |  |
| Burial   |  |  |  | 2/5/68   |  | Mt. Olivet Cem  |  |   |  | 2930 Frederick Ave Md.                        |  |  |  |                  |  |                            |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |   |  |   |  |   |  | 25a. REC'D BY REGISTRAR  |  |                  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |
| John J. Cowan & Son Inc.   |  |  |  |  |  |   |  |   |  |   |  | DATE FEB 6 1968  |  |                  |  | J. Charles Jones           |  |  |  |

02173

02184

RECORD OF DEEDS

DEEDS OF THE COUNTY OF ...

THIS DEED WAS RECORDED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF ... ON THE ... DAY OF ... 19... AT ... O'CLOCK ... M.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VR-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

|  |         |  |  |   |  |   |  |  |  |                          |  |        |  |      |  |            |  |
|--|---------|--|--|---|--|---|--|--|--|--------------------------|--|--------|--|------|--|------------|--|
| 1. DECEASED-NAME (Type or Print)   |         | First  |  | Middle  |  | Last  |  | 20. DATE KNOWN OF DEATH                      |  | Month                    |  | Day    |  | Year |  | 2b. HOUR   |  |
| CHARLES  |         | G.   |  | FLANAGAN  |  |   |  | FEB  |  | 25                       |  | 1968   |  |      |  | 9:00 A.M.  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS                              |  | 2c. DATE PRONOUNCED DEAD |  | Month  |  | Day  |  | Year       |  |
| M  | W       | 7/6/10   |  | 57 YRS.   |  | MONTHS  |  | DAYS   |  | FEB                      |  | 25     |  | 1968 |  | 10:00 A.M. |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH                           |  |                          |  |        |  |      |  |            |  |
| PA   |         | USA  |  | WIDOWED   |  | DIVORCED  |  | BALTO  |  |                          |  |        |  |      |  |            |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                          |  |        |  |      |  |            |  |
| ESSEX  |         | 128 WILTSHIRE  |  | ENG.  |  | MARTINS   |  |  |  |                          |  |        |  |      |  |            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                       |  |                          |  |        |  |      |  |            |  |
| MD   |         | BALTO  |  | ESSEX   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 128 WILTSHIRE                                |  |                          |  |        |  |      |  |            |  |
| 14. FATHER'S NAME  |         | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME                     |  | First                    |  | Middle |  | Last |  |            |  |
| CHARLES M.   |         | FLANAGAN   |  |   |  |   |  | MAY  |  | HARKINS                  |  |        |  |      |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |  |  |                          |  |        |  |      |  |            |  |
| UNK  |         | 176-10-9670  |  | HAZEL FLANAGAN  |  | ABOVE   |  |  |  |                          |  |        |  |      |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | PART 1. DEATH WAS CAUSED BY:   |  | IMMEDIATE CAUSE (a)   |  | DUE TO, OR AS A CONSEQUENCE OF                                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |        |  |      |  |            |  |
| 4100   |         | Coronary Occlusion   |  | Hypertensive C.V. Disease   |  |   |  |  |  |                          |  |        |  |      |  |            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |         | (b)  |  | (c)   |  |   |  |  |  |                          |  |        |  |      |  |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)  |         | 4201   |  |   |  |   |  |  |  |                          |  |        |  |      |  |            |  |
| 19a. DATE OF OPERATION   |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |                          |  |        |  |      |  |            |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |   |  |  |  |                          |  |        |  |      |  |            |  |
|  |         | HOUR A.M. P.M. 19  |  |   |  |   |  |  |  |                          |  |        |  |      |  |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County                                       |  | State                    |  |        |  |      |  |            |  |
|  |         |  |  |   |  |   |  |  |  |                          |  |        |  |      |  |            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22b. DATE SIGNED  |  | 2/29/68   |  |  |  |                          |  |        |  |      |  |            |  |
| ACTUAL SIGNATURE   |         | M.B. DAVIS   |  | M.D. - DANIELS AND VIRN   |  |   |  |  |  |                          |  |        |  |      |  |            |  |
| EXAMINER'S NAME (Type)   |         |  |  |   |  |   |  |  |  |                          |  |        |  |      |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |  | (County)                                     |  | (State)                  |  |        |  |      |  |            |  |
| BURIAL   |         | 2/28/68  |  | GARDENS OF FAITH  |  | BALTO.  |  | MD.  |  |                          |  |        |  |      |  |            |  |
| 24. FUNERAL DIRECTOR   |         | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                          |  |        |  |      |  |            |  |
| J.G. CONNELLY SONS   |         | 300 MACE   |  | FEB 29 1968   |  | Charles Judge   |  |  |  |                          |  |        |  |      |  |            |  |

4218C

50180

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                  |  |   |  |   |  |  |                                 |   |  |
|--|--|------------------|--|---|--|---|--|--|---------------------------------|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |  |   |  |   |  |  |                                 |   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |                  | First<br>JOHN  |   |  | Middle<br>FLEMING   |  |  | Last                            |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |  | 5. DATE OF BIRTH<br>April 8, 1909   |  | 6. AGE (In years)<br>58 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                 | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Mass.   |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore |   |  |
| 10. CITY OR TOWN OF DEATH<br>Oliver Beach (20)   |  |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Box 160 Greenbank Rd. |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Foreman |                                 |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Steel   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |                  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Oliver Beach   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |                                 | 13e. STREET AND NUMBER<br>Box 160 Greenbank Rd.                                     |  |
| 14. FATHER'S NAME<br>First Middle Last<br>John Fleming   |  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Mary Purdon |   |  |  |                                 |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>Yes   |  |                  | 16b. SOCIAL SECURITY NO.<br>(If yes give wpr or dates of service)<br>42-45   |   | 17. INFORMANT<br>Evelyn Fleming                              |   |  | ADDRESS<br>Same  |                                 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u><br>4100 DUE TO, OR AS A CONSEQUENCE OF <u>ACVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4201 |  |                  |  |   |  |   |  |  |                                 |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  |                  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?            |   |  |  |                                 | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>  |  |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19                 |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                                 |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |  | 21f. LOCATION Street or R.F.D. No.  |  |  | City or Town County State       |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                  |  |   |  |   |  |  |                                 |   |  |
| ACTUAL SIGNATURE<br><u>Theodore Patterson</u>  |  |                  | EXAMINER'S NAME (Type)<br>Theodore Patterson, M.D. 105 Main St.              |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED<br>2/17/68     |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Cremation   |  |                  | 23b. DATE<br>2/19/68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory  |   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                    |                                 |   |  |
| 24. FUNERAL DIRECTOR<br><u>Bruzdinski Funeral Home</u>   |  |                  |  |   | ADDRESS<br>1407 Eastern Ave.                                 |   |  | 25a. REC'D BY REGISTRAR<br>FEB 20 1968   |                                 | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Jones</u>                               |  |

02150

02150

02150



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02178</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02167</div>  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--------------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>LEWIS</b>   |  |  | First <b>McDANIEL</b>   |  |  | Middle <b>FORD, Sr.</b>   |  |  | Last  |  |  | 2a. DATE OF DEATH<br>2 Month 7 Day 68 Year          |  |  | 2b. HOUR<br>11:25 A            |  |  |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>Cau.</b>  |  |  | 5. DATE OF BIRTH<br><b>April 8, 1899.</b>   |  |  | 6. AGE (In years lost birthday)<br>68 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                      |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  | Md.   |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto., Maryland</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balto. Med. Center</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Retired Supervisor Fisher Body Co.</b>                         |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>  |  |  | 13c. CITY OR TOWN<br><b>Timonium</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>1322 Warwick Drive</b> |  |  |                                |  |  |
| 14. FATHER'S NAME<br><b>William</b>  |  |  | First <b>Ford</b>   |  |  | Middle <b>Lucy</b>  |  |  | Last <b>Ford</b>  |  |  |   |  |  |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown<br><b>No</b>  |  |  | (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-8627</b>  |  |  | 17. INFORMANT<br><b>Mrs. Ruth A. Ford</b>   |  |  | Address<br><b>(Same)</b>                            |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hematopericardium</b><br><b>410.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Rupture of heart</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Myocardial infarction and ASCVD</b> |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>              |  |  |   |  |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/3</b> , 19 <b>68</b> , to <b>2/7</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/7</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| 22b. SIGNATURE<br><b>John E. Adams</b>   |  |  | DEGREE  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>Feb. 7, 1968</b>   |  |  |   |  |  |                                |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John E. Adams, M.D.</b>   |  |  | 22e. ADDRESS<br><b>Greater Baltimore Medical Center</b>   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>2/10/68.</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dorchester Memorial Park</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cambridge, Md.</b>                          |  |  |   |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 8 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |   |  |  |                                |  |  |

02178

02178

1942

John S. Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02179 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 23b Film G398 2/28/68 kdk CERTIFICATE OF DEATH

02168

|  |  |   |   |   |  |   |  |   |   |  |  |
|--|--|---|---|---|--|---|--|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>MELVIN WATTS FORTUNE</b>  |  |   | 2a. DATE OF DEATH<br>Month <b>FEBRUARY</b> Day <b>11</b> Year <b>1968</b>                                 |   |  | 2b. HOUR<br><b>7:00PM</b>   |  |   |   |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>                       |   | 5. DATE OF BIRTH<br><b>12/10/99</b>   |  | 6. AGE (In years last birthday)<br><b>68</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b>      |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> Md.   |  |   |   |  |  |
| 1D. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>JANITOR</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>FACTORY</b>                         |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>BALTIMORE</b>   |   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1518 Retreat Street</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Kate Rollins</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>George Fortune</b>                                       |   |  |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>   |  |   | 16b. SOCIAL SECURITY NO.<br><b>WW I 219 01 00 31</b>  |   |  | 17. INFORMANT Address<br><b>Clin. Records, VA Hospital, Ft. Howard, Md.</b>                               |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE INTESTINAL OBSTRUCTION</b><br><b>5609</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>5702</b><br>(b) <b>MESENTERIC ARTERY THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>CHRONIC BRONCHITIS AND ARTERIOSCLEROTIC HEART DISEASE.</b>  |  |   |   |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                           |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                              |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>2/4/68</b> , 19__, to <b>2/11/68</b> , 19__, that (X) (we) lost the deceased on <b>2/11/68</b> , 19__, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.   |  |   |   |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>John D. Talbert, M.D.</b>   |  |   |   |   |  | 22c. DATE SIGNED<br><b>2/12/68</b>  |  |   |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>  |  |   |   |   |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>2/15/68</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Kelson Funeral Home</b>   |  |   | 25a. REC'D BY REGISTRAR<br><b>KELSON FUNERAL HOME</b>   |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   | DATE <b>FEB 15 1968</b>   |  |  |
| 1248 N. Calhoun Street, Baltimore, Md.   |  |   |   |   |  |   |  |   |   |  |  |

05110

05110

CO: 001 11 11 11 11 11

001 11

001 11

001 11

00

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

001 11

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                  |  |   |   |  |  |   |                                   |   |  |
|--|------------------|--|---|---|--|--|---|-----------------------------------|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                  |  |   |   |  |  |   |                                   |   |  |
| 1. DECEASED-NAME<br>(Type or Print)  |                  |  | First MARGUERITE Middle WINTER Last FOSTER  |   |  | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 2 13 1968                          |   | 2b. HOUR 11:40                    |   |  |
| 3. SEX<br>Female   | 4. RACE<br>White | 5. DATE OF BIRTH<br>July 3, 1896   | 6. AGE (In years last birthday)<br>#37 LYRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.                                | 2c. DATE PRONOUNCED DEAD<br>February 13 1968   |   | 2d. HOUR 11:30                    |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                     |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           |  | 9. COUNTY OF DEATH<br>Balto.   |   | P Md.                             |   |  |
| 10. CITY OR TOWN OF DEATH<br>Balto.  |                  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |                  |  | 13b. COUNTY<br>Balto.   |   | 13c. CITY OR TOWN<br>Balto.                                  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   | 13e. STREET AND NUMBER<br>500 Dunkirk Rd. |  |
| 14. FATHER'S NAME<br>William T. Tipplett, Sr.  |                  |  |   | 15. MOTHER'S MAIDEN NAME<br>E. Edna Freeman   |  |  |   |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) No   |                  |  | 16b. SOCIAL SECURITY NO.<br>217-12-0910   |   | 17. INFORMANT<br>John H. Winter, Jr. 1503 Maywood Ave. 21204 |  |   |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Pneumonia<br>486X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                  |  |   |   |  |  |   |                                   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>493X  |                  |  |   |   |  |  |   |                                   |   |  |
| 19a. DATE OF OPERATION   |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                   |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                    |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |                                   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |   | County State                      |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |  |   |   |  |  |   |                                   |   |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Edward F. Wilson, M.D.   |                  |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |  | 22b. DATE SIGNED<br>February 14, 1968  |   |                                   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Cremation   |                  | 23b. DATE<br>Feb. 16, 1968   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Greemount Crematory   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                                 |   |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204  |                  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 16 1968                  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Jones  |                                   |   |  |

598 J. L. A. Jansen et al.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |  |                                 |  |                 |  |                  |
|---|--|--|--|---|---|--|---------------------------------|--|-----------------|--|------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |  |                                 |  |                 |  |                  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |  |                                 |  |                 |  |                  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle  |   | Last   |                                 | 2a. DATE OF DEATH  |                 |  | 2b. HOUR         |
| MARY  |  | ANN  |  | FOSTER  |   | February 5 1968  |                                 |  | M               |  |                  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   |  | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |
| FEMALE  |  | CAU  |  | 7-7-87  |   |  | 80 YRS.                         |  | MONTHS DAYS     |  | HOURS MIN.       |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |   | NEVER MARRIED  |                                 | 9. COUNTY OF DEATH   |                 |  |                  |
| CARROLL Co MD   |  | USA  |  | WIDOWED   |   | DIVORCED   |                                 | BALTIMORE Md.  |                 |  |                  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                                 | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                 |  |                  |
| BALTO COUNTY  |  | G B M C  |  |   | HOUSE-WIFE  |  |                                 |  |                 |  |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?                                 |                                 | 13e. STREET AND NUMBER   |                 |  |                  |
| MD  |  | CARROLL  |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 | 3814 OAK AVE   |                 |  |                  |
| 14. FATHER'S NAME   |  | First  |  | Middle  |   | Last   |                                 | 15. MOTHER'S MAIDEN NAME   |                 | First Middle Last                            |                  |
| UNKNOWN   |  | GUNTHER  |  | UNKNOWN   |   | GIGGARD  |                                 |  |                 |  |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |                                 | Address  |                 |  |                  |
|   |  |  |  | 216-05-6969   |   | HUSBAND  |                                 | 3814 OAK AV Zone 7   |                 |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |   |  |                                 |  |                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |   |   |  |                                 |  |                 |  |                  |
| IMMEDIATE CAUSE (a) Pneumonia   |  |  |  |   |   |  |                                 |  |                 |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |  |                                 |  |                 |  |                  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |   |   |  |                                 |  |                 |  |                  |
| (b) Congestive failure  |  |  |  |   |   |  |                                 |  |                 |  |                  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |   |  |                                 |  |                 |  |                  |
| (c)   |  |  |  |   |   |  |                                 |  |                 |  |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |   |  |                                 |  |                 |  |                  |
| 4341  |  |  |  |   |   |  |                                 |  |                 |  |                  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |   | 20a. AUTOPSY?  |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                 |  |                  |
|   |  |  |  |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/> |                                 |  |                 |  |                  |
| 21a. ACCIDENT WAS UNDERLYING  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |                                 |  |                 |  |                  |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | HOUR A.M. Month Day Year 19  |  |   |   |  |                                 |  |                 |  |                  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |                                 |  |                 |  |                  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |   |   |  |                                 |  |                 |  |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |                                 |  |                 |  |                  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |   |   |  |                                 |  |                 |  |                  |
| M.G. Lazare   |  | 2/5/68   |  |   |   |  |                                 |  |                 |  |                  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |   |   |  |                                 |  |                 |  |                  |
|   |  | G B M C.   |  |   |   |  |                                 |  |                 |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)            |                                 |  |                 |  |                  |
| BURIAL  |  | 2-9-68   |  | Leister's Cemetery  |   | CARROLL Co, Maryland                                     |                                 |  |                 |  |                  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 24a. REC'D BY-REGISTRAR   |   | 24b. REGISTRAR'S SIGNATURE                               |                                 |  |                 |  |                  |
| EIKSWORTH ARMACOST  |  | 4600 Liberty Hgts  |  | F--   |   | 6 1968   |                                 | Charles Judge  |                 |  |                  |

02110

02110

02110

AN

HOME - FE

HAWAII AND OCEAN

02110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon addres. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                  |  |   |  |  |  |  |  |   |  |
|--|--|----------------------------------|--|---|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                                  |  |   |  |  |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |                                  |  |   |  |  |  |  |  |   |  |
| 02182  |  |                                  |  |   |  |  |  |  |  |   |  |
| 02171  |  |                                  |  |   |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>MARYLAND  |  |                                  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hereford</u>  |  |                                  |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hereford</u>  |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Mt. Carmel Road near York Rd.</u>   |  |                                  |  |   |  | d. STREET ADDRESS<br><u>Mt. Carmel Rd., near York Rd.</u>  |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Edwin A. Fowble, Sr.</u><br>First Middle Last   |  |                                  |  |   |  | 4. DATE OF DEATH<br><u>February 14, 1968</u><br>Month Day Year   |  |  |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | B. DATE OF BIRTH<br><u>March 11, 1881</u>  |  | 9. AGE (In years last birthday)<br><u>86</u> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer-retired</u>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Self-employed</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>John Fowble</u>  |  |                                  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ellen Towney</u>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service)<br><u>No</u>   |  |                                  |  | 16. SOCIAL SECURITY NO.<br><u>218-05-6018</u>   |  | 17. INFORMANT<br><u>Family records</u>   |  |  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>C.I. C.V. disease</u><br><u>4129</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____ |  |                                  |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>4221</u>   |  |                                  |  |   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)               |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb 14, 1968</u> to <u>Feb 14, 1968</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> 19 <u>68</u> , and that death occurred at <u>4P</u> M, from causes and on the date stated above.                                       |  |                                  |  |   |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br><u>A. M. France</u>  |  |                                  |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  | 22b. DATE SIGNED<br><u>2/15/68</u>                 |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>A. M. FRANCE</u>  |  |                                  |  |   |  | 22d. ADDRESS<br><u>Parkton Md</u>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |                                  |  | 23b. DATE THEREOF<br><u>Feb. 17, 1968</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Grove Cemetery</u>  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Hereford, Balto. Co., Md.</u>                 |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>  |  |                                  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>FEB 20 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u> |  |   |  |

17120

8318

8318

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cobag papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

Item 2 Film G390 3/1/68 KK

02183

02172

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> Maryland  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore. Pikesville, Md.</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore. Pikesville, Md.</b>                                       |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Milford Manor Nursing Home</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Bessie</b> Middle <b>Fox</b> Last <b>Fox</b>  |                                  | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>26</b> Year <b>1968</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1893</b>                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  | 9. AGE (In years last birthday) yrs.<br><b>75</b> |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Russia</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Paseach Mizrach</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Gittel</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Mr. Jerome Feld</b>   |                                  | Address<br><b>3715 Clarinthe Rd.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br><b>4109</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio sclerosis</b> DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b><br><b>years</b> |                                  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>4201</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>64</b> , to <b>2-26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-22</b> , 19 <b>68</b> , and that death occurred at <b>3:10 A.M.</b> , from causes and on the date stated above.  |                                  |   |   |
| 22a. SIGNATURE<br><b>David J. Miller</b> M.D.   |                                  | 22b. DATE SIGNED<br><b>2-26-68</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>David J. Miller</b>  |                                  | 22d. ADDRESS<br><b>Linson Rd. Owings Mills, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>Feb. 26th. 1968</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Shomrei Hadath Cem.</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Rosedale, Baltimore, Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Hyman S. Lewis &amp; Son</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>FEB 28 1968</b>   |   |
| ADDRESS<br><b>P.O. Box 65 Harrison, Md.</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

02182

CERTIFICATE OF DEATH

02182

*[Faint, mostly illegible text, likely a form or certificate, with some handwritten entries.]*

*[Vertical stamp or text, possibly "MAILED" or similar.]*

FEB 1 1968



Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
30M REV. 1/68

|  |  |  |  |  |   |  |  |   |  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |
|--|--|--|--|--|---|--|--|---|--|--|--|---|-----------------------------|--|-----------------------------|--|-----------------------------|--|--|--------------------|--|
| 02184  |  |  |  |  |   |  |  |   |  | 02173  |  |   |                             |  |                             |  |                             |  |  |                    |  |
| 1. DECEASED NAME (Type or print) First Middle Last<br>Arthur Lee France  |  |  |  |  |   |  |  |   |  | 2a. DATE OF DEATH Month Day Year<br>Feb. 11, 1968  |  |   |                             |  |                             |  |                             |  |  | 2b. HOUR<br>6 P.M. |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>White   |  |   |  | 5. DATE OF BIRTH<br>Jan. 11, 1881  |   |  |  | 6. AGE (In years last birthday)<br>87 YRS.                           |   |                             |  | IF UNDER 1 YEAR MONTHS DAYS |  | IF UNDER 24 HRS. HOURS MIN. |  |  |                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |  | 9. COUNTY OF DEATH<br>Baltimore County Md.                           |   |                             |  |                             |  |                             |  |  |                    |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville Baltimore City  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>None Ridgeway Manor Nursing Home |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Glass Blower  |   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Self-Empl.                      |   |                             |  |                             |  |                             |  |  |                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  | 13b. COUNTY<br>---   |  |   |  | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>415 Rosecroft Terrace                      |   |                             |  |                             |  |                             |  |  |                    |  |
| 14. FATHER'S NAME First Middle Last<br>Thomas France   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Sarah Shipley |  |  |   |  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>086-05-9696  |  |   |  | 17. INFORMANT<br>Mrs. Helen M. Berbus- Balto., Md.   |   |  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Generalized CARCINOMATOSIS<br>185X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA Prostate<br>2Y1F5+<br>(c) |  |  |  |  |   |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 Y1F+<br>2 Y1F5+ |                             |  |                             |  |                             |  |  |                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>177X   |  |  |  |  |   |  |  |   |  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                             |  |                             |  |                             |  |  |                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br>P.M. 19  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 67, to 2/11, 1968, that (I) (we) last saw the deceased alive on 2/10 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |  |  |  |   |  |  |   |  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |
| 22b. SIGNATURE<br>Thos E. Roach  |  |  |  |  |   |  |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |   | 22c. DATE-SIGNED<br>2/12/68 |  |                             |  |                             |  |  |                    |  |
| 22d. PHYSICIAN'S NAME (Type)<br>5550 B220 NATE PIKE  |  |  |  |  | 22e. ADDRESS<br>THOS E ROACH                                |  |  |   |  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>2/13/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  |  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore - AACounty - Md.                  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |
| 24. FUNERAL DIRECTOR<br>Sterling Funeral Estate-736 Edmondson Ave.-21228 of Catonsville  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 14 1968                 |  |  | 25b. REGISTRAR'S SIGNATURE<br>James Judge   |  |  |  |   |                             |  |                             |  |                             |  |  |                    |  |

15180

2150

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02185

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02174

|  |         |                              |  |  |  |   |  |  |  |   |  |  |  |            |  |
|--|---------|------------------------------|--|--|--|---|--|--|--|---|--|--|--|------------|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First                        |  | Middle   |  | Last  |  | 20. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month Day Year        |  |   |  | 2b. HOUR                                       |  |            |  |
| CRYSTAL FRAZIER  |         |                              |  |  |  |   |  | 2 23 19  |  |   |  | 6810:45  |  |            |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                          |  | IF UNDER 24 HRS<br>HOURS MIN.  |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year                      |  |  |  | 2d. HOUR a |  |
| Female   | White   | Oct 21/21                    |  | 46 YRS.  |  |   |  |  |  | February 23 19 68   |  |  |  | 10:45      |  |
| 70. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                                      |  |  |  |   |  |  |  |            |  |
| Md   |         | U.S.                         |  |  |  | Balto.  |  |  |  |   |  |  |  |            |  |
| 10. CITY OR TOWN OF DEATH  |         |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY              |  |            |  |
| Balto.   |         |                              |  | St. Joseph Hospital  |  |   |  | Checker  |  |   |  | A & P. Store                                   |  |            |  |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              |  | 13b. COUNTY  |  | 13c. CITY OR TOWN                                       |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |  |  |            |  |
| Md   |         |                              |  | Balto.   |  | Balto.  |  |  |  | 8824 Victory Ave.   |  |  |  |            |  |
| 14. FATHER'S NAME  |         |                              |  | First  |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |            |  |
| Elmer Bowen  |         |                              |  |  |  |   |  |  |  | Ethel M. Wink   |  |  |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS  |  |   |  |  |  |            |  |
| no   |         |                              |  | no   |  | ?   |  | Wm.F. Frazier, Sr. 8824 Victory Ave  |  |   |  |  |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Peritonitis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <u>Perforation of duodenal ulcer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |                              |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |                              |  |  |  |   |  |  |  |   |  |  |  |            |  |
| 19a. DATE OF OPERATION   |         |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |   |  |  |  |            |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                              |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |   |  |  |  |            |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         |                              |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |   |  |  |  |            |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |  |   |  |  |  |   |  |  |  |            |  |
| ACTUAL SIGNATURE <u>Edward F. Wilson</u>   |         |                              |  | M.D.   |  |   |  | 22b. DATE SIGNED<br>Feb. 23, 1968  |  |   |  |  |  |            |  |
| EXAMINER'S NAME (Type)<br>Edward F. Wilson, M.D.   |         |                              |  | ADDRESS (Street, city, town, or county)  |  |   |  |  |  |   |  |  |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |         |                              |  | 23b. DATE<br>Feb 26, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Memorial |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Taylor Ave. Md |  |  |  |            |  |
| 24. FUNERAL DIRECTOR<br>Austin E. Donovan  |         |                              |  | ADDRESS<br>3818 Roland Ave   |  |   |  | 25a. REC'D BY REGISTRAR<br>FEB 26 1968   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Jones |  |            |  |

02182

02182

FEB 8 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02186</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02175</div>  |  |  |  |  |                                    |  |  |   |  |  |  |
|---|--|--|--|--|------------------------------------|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |                                    | 2a. DATE OF DEATH  |  |   | 2b. HOUR   |  |  |
| First Middle Last<br>Francis C. FREDERICK   |  |  |  |  |                                    | Month Day Year<br>February 18 68   |  |   | 10pm M   |  |  |
| 3. SEX  |  |  | 4. RACE  |  |                                    | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday)                                      |  |  |
| Male  |  |  | white  |  |                                    | 8-6-01   |  |   | 66 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH   |  |  |
| Pennsylvania  |  |  | USA  |  |                                    |  |  |   | Balto. Md.   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  |  |
| Towson  |  |  |  | St. Josephs Hospital   |                                    |  |  | MAINTENANCE   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  | 13b. COUNTY  |                                    | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                       |  |
| Maryland  |  |  |  | BALTO  |                                    | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  | 708 Maryland Ave. 21221                      |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  |  |                                    | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |   |  |  |  |
| HENRY B. FREDERICK  |  |  |  |  |                                    | ANN REIMAN   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  | 16b. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT  |  |   |  | Address                                      |  |
| UNK   |  |  |  | 216-03-0627  |                                    | MARY FREDERICK   |  |   |  | ABOVE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                                    |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |                                    |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Congestive heart failure  |  |  |  |  |                                    |  |  |   |  |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                                    |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |                                    |  |  |   |  |  |  |
| (b) Myocardial infarction   |  |  |  |  |                                    |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                                    |  |  |   |  |  |  |
| (c) Coronary arteriosclerosis   |  |  |  |  |                                    |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |                                    |  |  |   |  |  |  |
| 4201  |  |  |  |  |                                    |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY?  |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |  |                                    | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |
|   |  |  |  |  |                                    |  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   | 18   |  |  |
|   |  |  |  |  |                                    |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from January 26, 1968, to February 1968, that (I) (we) last saw the deceased alive on February 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                    |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |                                    |  |  |   | 22c. DATE SIGNED   |  |  |
| Sum D. Mue  |  |  |  |  |                                    |  |  |   | February 19, 1968  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |                                    | 22e. ADDRESS   |  |   |  |  |  |
| Lawrence F. Misanik, M.D.   |  |  |  |  |                                    | 7620 York Rd., Towson, Md. 21204   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| REMOVAL   |  |  | 2/22/68  |  | WOODLAWN CEM                       |  |  | ALLEN TOWN PA   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |                                    | 25a. REC'D BY REGISTRAR  |  |   | 25b. REGISTRAR'S SIGNATURE   |  |  |
| J.G. CONNELLY SONS  |  |  |  |  |                                    | 300 MACE   |  |   | FEB 21 1968  |  |  |

05178

03180

RECEIVED

1-1

1-1

x

1

x

RECEIVED

RECEIVED



RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

02187

02175

|   |  |  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Elizabeth</i>  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month <i>Feb.</i> Day <i>13</i> Year <i>1968</i>   |  |  | 2b. HOUR<br><i>6 P.M.</i>   |  |  |
| 3. SEX<br><i>female</i>   |  |  | 4. RACE<br><i>white</i>  |  |  | 5. DATE OF BIRTH<br><i>Dec. 6, 1875.</i>  |  |  | 6. AGE (In years last birthday)<br><i>92</i> YRS.   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Catonsville</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>House In the Pines N.H.</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>USA</i>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>   |  |  | 13b. COUNTY<br><i>Baltimore</i>  |  |  | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><i>939 N. Collington Ave.</i>   |  |  | 14. FATHER'S NAME<br>First <i>George</i> Middle <i>Giel</i> Last <i>Giel</i>                                   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br><i>Carroll Fuchs</i>   |  |  | Address<br><i>8805 Alnwick Rd. 21234</i>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial Ischemia</i><br>4299 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Generalized arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i> |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 mo.</i><br><i>10 yr</i>                    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>4221</i>   |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-5-1967</i> , to <i>2-13-1968</i> , that (I) (we) last saw the deceased alive on <i>2-12-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>Wilmer K. Gallagher M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  |  |   |  |  | 22c. DATE SIGNED<br><i>2-13-68</i>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Wilmer K. Gallagher</i>  |  |  |  |  |  |   |  |  | 22e. ADDRESS<br><i>6209 Frederick Ave, Balt., Md. 21228</i>                                     |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |  | 23b. DATE<br><i>2/17/68.</i>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer Cemetery</i>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Md.</i>                          |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><i>Leonard J. Ruck, Inc Baltimore, Md.</i>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>FEB 15 1968</i>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

27486

315

1900, 1901, 1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 25

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |   |  |   |  |
|---|--|--|--|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |   |  |   |  |
| 02188   |  |  |  |   | 02177   |   |  |   |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Mary L. Gambrill</b>   |  |  |  |   | 2a. DATE OF DEATH<br><b>Feb.</b> Month <b>2</b> Day <b>68</b> Year        |   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>March 12, 1909</b>   |   | 6. AGE (In years last birthday)<br><b>58</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore Co.</b> Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mt. Washington</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>6719 Broadview Rd</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>housewife</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Balto Co.</b>  |  | 13c. CITY OR TOWN<br><b>Mt. Washington</b>  |   | 13d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 13e. STREET AND NUMBER<br><b>6719 Broadview Rd. 21209</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>August Flemming</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Hammel</b>               |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>---</b>   |  | 17. INFORMANT Address<br><b>Mr. George C. Gambrill 6719 Broadview Rd. (9)</b>   |   |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of breast</b><br><b>1621</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Carcinoma of lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4 months</b><br><b>ap 1966</b> |  |  |  |   |   |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>163X</b>   |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , 19 <b>1966</b> , to <b>1968</b> , 19 <b>1968</b> , that (I) (we) last saw the deceased alive on <b>2-1-68</b> 19 <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br><b>Harold H. Burns MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |   | 22c. DATE SIGNED<br><b>2-2-1968</b>                                       |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Harold Burns</b>   |  |  |  |   | 22e. ADDRESS<br><b>8106 Harford Road</b>                                  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-5-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Butler Methodist Church</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Butler Balto Co Md</b>                      |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Frank X. Leitz</b>   |  | ADDRESS<br><b>814 W 36 city Md</b>   |  | 25a. REC'D BY REGISTRAR<br><b>FEB 5 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |   |  |

57150

28180

## CERTIFICATE OF DEATH

02176

|  |  |  |  |   |  |  |  |   |                                |   |                                |  |
|--|--|--|--|---|--|--|--|---|--------------------------------|---|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Milford</b>   |  | First <b>C.</b>  |  | Middle <b>Garrett</b>   |  | Last   |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>20</b> Year <b>1968</b> |                                |   | 2b. HOUR<br>M                  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>July 8, 1910</b>   |  |  | 6. AGE (In years<br>last birthday)<br><b>57</b> YRS. |   | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |  |   |                                |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>6141 Parkhaven Rd.</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Foreman-Bethlehem Steel Co.</b> |  |   |                                | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  | 13e. STREET AND NUMBER<br><b>8141 Parkhaven Rd.</b>                       |                                |   |                                |  |
| 14. FATHER'S NAME First <b>Archie</b>  |  | Middle <b>Garrett</b>  |  | Last  |  | 15. MOTHER'S MAIDEN NAME First <b>Margaret</b>   |  | Middle <b>Schlaile</b>  |                                | Last  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>213-07-4579</b>  |  | 17. INFORMANT (Wife) <b>Mrs. Margaret F. Garrett, 8141 Parkhaven Rd.</b>   |  |   |                                |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <b>Metastasis squamous cell ca of unknown</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>origin (poss. lung)</b><br>(c) |  |  |  |   |  |  |  |   |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>2-3- days</b> |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>163X</b>  |  |  |  |   |  |  |  |   |                                |   |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |                                |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |                                |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |                                |   |                                |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11-15</b> , 19 <b>63</b> , to <b>2-20</b> , 19 <b>68</b> , that (1) (we) lost<br>saw the deceased alive on <b>2-20</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (1) (we) (did) (did not) view the body after death. <b>12-23</b>   |  |  |  |   |  |  |  |   |                                |   |                                |  |
| 22b. SIGNATURE<br><b>Charles E. Thompson</b>   |  | 22c. DATE SIGNED<br><b>2/20/68</b>   |  | 22d. PHYSICIAN'S<br>NAME (Type) <b>Charles E. Thompson M.D.</b>   |  |  |  |   |                                |   |                                |  |
| 22e. ADDRESS<br><b>2903 W. Woodwell Rd. Dundalk, Md. 21222</b>   |  |  |  |   |  |  |  |   |                                |   |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE<br><b>2/23/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |  |   |                                |   |                                |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 26 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |                                |   |                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514  
30M REV. 1-68

02190

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02179

|   |  |  |  |   |  |   |  |  |                                  |                |                                   |   |  |
|---|--|--|--|---|--|---|--|--|----------------------------------|----------------|-----------------------------------|---|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>Karen   |  | Middle<br>Ann   |  | Last<br>Garrison  |  | 2a. DATE OF DEATH<br>Month<br>2<br>Day<br>28<br>Year<br>68                     |                                  |                | 2b. HOUR<br>8:20P <sup>M</sup>    |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>12/14/67  |  |   | 6. AGE (In years<br>last birthday)<br>YRS. 2<br>MONTHS 15<br>DAYS 15 |  | IF UNDER 1 YEAR<br>HOURS<br>MIN. |                | IF UNDER 24 HRS.<br>HOURS<br>MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |                                  |                |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Rosewood State Hospital |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>none (dependent)  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>--                           |  |                                  |                |                                   |   |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>--  |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>620 Linard St.,                                      |                                  |                |                                   |   |  |
| 14. FATHER'S NAME<br>First<br>Marvin  |  | Middle<br>M.   |  | Last<br>GARRISON  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Phyllis  |  | Middle<br>Ann  |                                  | Last<br>BROOKS |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>--   |  | 17. INFORMANT<br>Address<br>Rosewood Records, Owings Mills, Md, 21117   |  |   |  |  |                                  |                |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Aspiration of Stomach Contents<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Multiple Congenital Anomalies, Cleft palate<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Mafotacial Monster<br>7589<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. 7589 |  |  |  |   |  |   |  |  |                                  |                |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Terminal<br>2 months |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Premature Birth, 35wk gestation, 5lb. 4oz weight at Autopsy   |  |  |  |   |  |   |  |  |                                  |                |                                   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br>yes |                                  |                |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>8:20P <sup>M</sup> 2 28 1968                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                                  |                |                                   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |  |                                  |                |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/26/1968, to 2/28/1968, that (I) (we) last<br>saw the deceased alive on 2/28/1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |                                  |                |                                   |   |  |
| 22b. SIGNATURE<br>Richard A. Jones  |  | DEGREE   |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  | 22c. DATE SIGNED<br>2/28/68   |  |  |                                  |                |                                   |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Richard A. Jones,  |  | 22e. ADDRESS<br>Rosewood State Hosp., Owings Mills, Md.  |  |   |  |   |  |  |                                  |                |                                   |   |  |
| 23a. BURIAL, CREMATION,<br>or other disposal (Specify)<br>Burial  |  | 23b. DATE<br>March 4, 68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Rosewood Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Owings Mills, Md.                              |  |  |                                  |                |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>J. F. Eline & Sons Reisterstown, Md.  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 6 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                                    |                                  |                |                                   |   |  |

453

2

Referring to

bio-robot

1992

© 2004 Blackwell Publishing Ltd *Journal of Internal Medicine* 255: 105–112

... 1950

$\rho = \frac{1}{2}$

2004

1990-1991

•

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02191</div> <div> <div>2</div> <div>1</div> </div> <div> <div>02180</div> <div>15-66688</div> </div>   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>Jeffrey</b>  |  |  | Middle<br><b>A.</b>   |  |  | Last<br><b>G E A R</b>   |  |  | 2a. DATE OF DEATH<br>Month<br><b>February</b> Day<br><b>22</b> Year<br><b>1968</b>            |  |  | 2b. HOUR<br><b>9:35AM</b>                |  |
| 3. SEX<br><b>Male</b>   |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>April 4, 1967</b>  |  |  | 6. AGE (In years last birthday)<br>YRS. <b>10</b> MONTHS <b>17</b> DAYS <b>17</b> HOURS <b>17</b> MIN. |  |  | IF UNDER 1 YEAR<br>MONTHS <b>10</b> DAYS <b>17</b>  |  |  | IF UNDER 24 HRS.<br>HOURS <b>17</b> MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>None</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |  | 13e. STREET AND NUMBER<br><b>3480 Loganview Drive</b>   |  |  |  |  |
| 14. FATHER'S NAME<br>First<br><b>Herbert</b> Middle<br><b>Gear</b> Last<br><b>Gielner</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>Kathleen</b> Middle<br><b>Gielner</b> Last<br><b>Gielner</b>       |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>No</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>  |  |  | 17. INFORMANT (Father) Address<br><b>Mr. Herbert Gear, 3480 Loganview Drive, Dundalk, Md.</b> |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>486X</b> <b>and septicemia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>493X</b> |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                   |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |   |  |  |  |  |
| 22a. I certify that <del>no</del> (this hospital) attended the deceased from <b>2/16/</b> , 19 <b>68</b> , to <b>2/22/</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/22/</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Ludilina M. Oteyza</b>   |  |  | DEGREE<br><b>M.D.</b>  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>February 22, 1968</b>   |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ludilina M. Oteyza, M.D.</b>   |  |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |  |  |   |  |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2/24/68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                                 |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 2829 Hudson St. Balto. Md,</b>   |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 26 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |   |  |  |  |  |

03130

03130

11 5 11

A

2-11-50

11 5 11

11 5 11

11 5 11

11 5 11

11 5 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br><b>THOMAS</b>  |  | Middle<br><b>KENNETH</b>  |  | Last<br><b>GERACI</b>   |  | 2a. DATE OF DEATH<br>2 Month 26 Day 68 Year  |  | 2b. HOUR<br>4:00AM                           |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>1/21/09</b>  |  | 6. AGE (In years last birthday)<br><b>59</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>ANNAPOLIS, MD.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY, Md.</b>  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>ATTENDANT</b>                               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SERVICE STATION</b>                        |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>STATE <b>MARYLAND</b>  |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>  |  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   |  | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET AND NUMBER<br><b>165 Green Street</b>                                  |  |  |  |
| 14. FATHER'S NAME<br>First <b>FRANK B.</b> Middle <b>GERACI</b> Last  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First <b>AGNES</b> Middle <b>SMITH</b> Last   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><b>YES</b> (If yes give war or dates of service)<br><b>WW II</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214 05 04 08</b>   |  | 17. INFORMANT<br>Address<br><b>CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><b>5718</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>FATTY INFILTRATION OF LIVER</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5810</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>ARTERIOSCLEROTIC HEART DISEASE AND CHRONIC BRAIN SYNDROME</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |  |  |  |  |
| 22a. I certify that <b>X</b> (this hospital) attended the deceased from <b>2/22/68</b> , 19____, to <b>2/26/68</b> , 19____, that <b>X</b> (we) last saw the deceased alive on <b>2/26/68</b> , 19____, and that in <b>MD</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>X</b> (we) (did) (did not) view the body after death.                                 |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>J. D. Talbert, MD</b>  |  |   |  |   |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2/26/68</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>   |  |   |  |   |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2-29-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. MART'S CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ANNAPOLIS, MARYLAND</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John M. Taylor &amp; Sons.</b>   |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>TAYLOR'S FUNERAL HOME</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |  |  |  |
|   |  |   |  |   |  | DATE<br><b>FEB 28 1968</b>  |  |  |  |  |  |



02130

02130

THOMAS, RICHARD L.      BIRTH      1918      DEATH      1978      GRAVE      1978

WHITE      1918      1978      1978      1978      1978

ARMED & DANGEROUS      U.S.A.      1978      1978      1978      1978

LOST BURIAL      VETERAN'S ADMINISTRATION HOSPITAL      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978

ARMED & DANGEROUS      1978      1978      1978      1978      1978



CERTIFICATE OF DEATH

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br><b>Patricia Ann Gerber</b>   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>2 14 68</b>   |  | 2b. HOUR<br>M<br><b>6</b>                                       |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>6/22/30</b>  |   | 6. AGE (In years<br>lost birthday)<br><b>37</b> YRS.       | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Catonsville 443 Chalfonte Dr.</b> | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Housewife</b>  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>- -</b>  |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>Balto.</b>  | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>443 Chalfonte Drive 21228</b> |   |
| 14. FATHER'S NAME First Middle Last<br><b>John L. Cooper</b>   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Thelma T. Marvel</b>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>213-30-3173</b>  | 17. INFORMANT Address<br><b>William J. Gerber, 443 Chalfonte Drive 21228</b>                    |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>metastatic Carcinoma</b><br><b>174 x</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Primary Breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>170 x</b>   |   |   |   |  |   |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/25, 1964</b> , to <b>2/15 1968</b> , that (I) (we) last saw the deceased alive on <b>2/14 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>James N. Frederick</b>  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      | 22c. DATE SIGNED<br><b>2/15/68</b>  |  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. James Frederick</b>   |   | 22e. ADDRESS<br><b>1311 Francis Ave.</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REINTERMENT<br><b>Burial</b>   | 23b. DATE<br><b>2/17/68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                           |  |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Howard H. Hubbard , 4107 Wilkens Ave. 21229</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 20 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

30-35

1

322

313

八

020 22537

1553-54

• • • • •

7.3

100

• *bp*

1900

3 2 1

• 1

2000-2001 2001-2002 2002-2003 2003-2004 2004-2005

1971 2 21 314

3.21

152

1

150

1943: 6

23:04

3

5

... ..

153

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02194  |               |  |        | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                          |  |                                 | 02183                  |      |  |  |
|--|---------------|--|--------|--|--------------------------|--|---------------------------------|------------------------|------|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |               | First  | Middle | Last   | 2a. DATE OF DEATH        |  | 2b. HOUR                        |                        |      |  |  |
| Frederick  |               |  |        | Gerstley   | Month 2                  | Day 23   | Year 1968                       | 2 A M                  |      |  |  |
| 3. SEX   | Male          | 4. RACE  | White  | 5. DATE OF BIRTH   | 9-8-1884                 |  | 6. AGE (In years lost birthday) | 83 YRS.                |      |  |  |
| 7a. BIRTHPLACE (State or foreign country)  | Waymouth Mass | 7b. CITIZEN OF WHAT COUNTRY?   | U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH       |  |                                 |                        |      |  |  |
| Fullerton  |               | 8219 Belair Road   |        | Superent   |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |                                 |                        |      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |               | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                 | 13e. STREET AND NUMBER |      |  |  |
| Md.  |               | Baltimore  |        | Fullerton  |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                 | 8219 Belair Road 21236 |      |  |  |
| 14. FATHER'S NAME  |               | First  | Middle | Last   | 15. MOTHER'S MAIDEN NAME |  | First                           | Middle                 | Last |  |  |
| Arthur Gerstley  |               |  |        |  | Mary                     |  |                                 |                        |      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)  |               | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT  |                          | Address  |                                 |                        |      |  |  |
| No   |               | 212-01-0441  |        | Mrs Eugenia Gerstley   |                          | 8219 Belair Road   |                                 |                        |      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular Disease</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Parkinsonism and cerebral insufficiency</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>3-4 yrs standing</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>undet.</u>   |               |  |        |  |                          |  |                                 |                        |      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |               |  |        |  |                          |  |                                 |                        |      |  |  |
| 4221   |               |  |        |  |                          |  |                                 |                        |      |  |  |
| 19a. DATE OF OPERATION   |               | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY?  |                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                 |                        |      |  |  |
|  |               |  |        | YES <input type="checkbox"/> NO <input type="checkbox"/>   |                          |  |                                 |                        |      |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |               | 21b. TIME OF INJURY  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                          |  |                                 |                        |      |  |  |
| 21d. INJURY OCCURRED   |               | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION  |                          |  |                                 |                        |      |  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |               |  |        | Street or R.F.D. No. City or Town County State   |                          |  |                                 |                        |      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>64</u> , to <u>2-23</u> , 19 <u>68</u> , that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <u>19 Feb</u> 19 <u>68</u> , and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) (did) ( <input type="checkbox"/> ) view the body after death. |               |  |        |  |                          |  |                                 |                        |      |  |  |
| 22b. SIGNATURE   |               |  |        | 22c. DATE SIGNED   |                          |  |                                 |                        |      |  |  |
| <u>John C. Hyle</u> M.D. DEGREE  |               |  |        | <u>2-23-68</u>   |                          |  |                                 |                        |      |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |               |  |        | 22e. ADDRESS   |                          |  |                                 |                        |      |  |  |
| JOHN C. Hyle   |               |  |        | 7527 Belair Rd Baltimore   |                          |  |                                 |                        |      |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |               | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION (City or Town) (County) (State)  |                                 |                        |      |  |  |
| Burial   |               | 2-24-1968  |        | Parkwood Cemetery  |                          | Baltimore Co. Md.  |                                 |                        |      |  |  |
| 24. FUNERAL DIRECTOR   |               |  |        | 25a. REC'D BY REGISTRAR  |                          | 25b. REGISTRAR'S SIGNATURE   |                                 |                        |      |  |  |
| Lorraine Funeral Home 7401 Belair Road 36  |               |  |        | DATE FEB 26 1968   |                          | <u>Charles Jones</u>   |                                 |                        |      |  |  |

05180

05180

05180

05180

Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02195

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02184

|   |  |  |  |   |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(Type or print)   |  | First<br>THOMAS BENTON   |  | Middle<br>GILL, JR.   |  | Last  |  | 6. DATE OF DEATH<br>Month Day Year<br>February 13, 1968 |  | 2b. HOUR<br>PM<br>2:15                                    |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>May 18, 1928  |  | 6. AGE (In years<br>last birthday)<br>39 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                          |  | IF UNDER 24 HRS.<br>HOURS MIN.                            |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Essex (21)   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>149 Bladen Rd.                                      |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>General Manager   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Restaurant  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Essex (21)   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>149 Bladen Road               |  |   |  |
| 14. FATHER'S NAME First Middle Last<br>Thomas B. Gill, Sr.  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Catherine Pitman  |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>46-48 214-22-0367  |  | 17. INFORMANT Address<br>Ellen Gill Same  |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial infarction<br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201<br>(b) Atherosclerotic coronary vas. disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) 2 yrs<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>Diabetes mellitus, essentially permanent |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Immediate |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1967, to Feb 13, 1968, that (I) (we) last saw the deceased alive on Feb 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>Louis Semenoff  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2/14/68   |  |   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Louis Semenoff, M.D.  |  | 22e. ADDRESS<br>2108 Orems Rd. Balto., Md. 21220   |  |   |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>2/16/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Co., Md.                             |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home 1407 Eastern Ave.  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 15 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge             |  |   |  |



38130

38130

My account of the  
republican movement in  
the United States

By William D. Howells

8.11.12

X [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |                                    |   |      |   |  |  |                        |                                   |  |
|---|--|--|--|--|------------------------------------|---|------|---|--|--|------------------------|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |                                    |   |      |   |  |  |                        |                                   |  |
| CERTIFICATE OF DEATH  |  |  |  |  |                                    |   |      |   |  |  |                        |                                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  |  | Middle                             |   | Last |   | 2a. DATE OF DEATH<br>Month Day Year  |  | 2b. HOUR<br>10:05 A.M. |                                   |  |
| DR. LOUIS   |  |  | J.   |  | GLASS                              |   |      |   | FEBRUARY 29, 1968  |  |                        |                                   |  |
| 3. SEX  |  |  | 4. RACE  |  |                                    | 5. DATE OF BIRTH  |      |   | 6. AGE (In years last birthday)  |  |                        | 7. IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| MALE  |  |  | WHITE  |  |                                    | SEPT. 15, 1904  |      |   | 63 YRS.  |  |                        |                                   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   | 9. COUNTY OF DEATH   |  |                        |                                   |  |
| BALTIMORE, MD.  |  |  | U.S.A.   |  |                                    |   |      |   | BALTIMORE Md.  |  |                        |                                   |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |      |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |                                   |  |
| PIKESVILLE  |  |  | EDEN ROC WAY & OLD COURT ROAD  |  |                                    | PHYSICIAN   |      |   | MEDICAL  |  |                        |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN   |      |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                        | 13e. STREET AND NUMBER            |  |
| MARYLAND  |  |  | BALTIMORE  |  |                                    | PIKESVILLE  |      |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |                        | EDEN ROC WAY #21208               |  |
| 14. FATHER'S NAME   |  |  | First  |  | Middle                             |   | Last |   | 15. MOTHER'S MAIDEN NAME   |  |                        | First Middle Last                 |  |
| SIMON   |  |  | GLASS  |  |                                    |   |      |   | JENNIE   |  |                        | MILLER                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT   |      |   | Address  |  |                        |                                   |  |
| NO  |  |  |  |  |                                    | MRS. MILDRED GLASS  |      |   | EDEN ROC WAY & OLD COURT RD.   |  |                        |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRAIN TUMOR (GLIOBLASTOMA MULTIFORME)</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u> |  |  |  |  |                                    |   |      |   |  |  |                        |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>1930</u>   |  |  |  |  |                                    |   |      |   |  |  |                        |                                   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY?   |      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |                                   |  |
| 12/9/67   |  |  | BRAIN TUMOR  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |      |   |  |  |                        |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |   |  |  |                        |                                   |  |
|   |  |  |  |  |                                    |   |      |   |  |  |                        |                                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No.  |      |   | City or Town   |  | County State           |                                   |  |
|   |  |  |  |  |                                    |   |      |   |  |  |                        |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/9</u> , 19 <u>67</u> , to <u>2/29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/28</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |                                    |   |      |   |  |  |                        |                                   |  |
| 22b. SIGNATURE  |  |  | 22c. DATE, SIGNED  |  |                                    | 22d. PHYSICIAN'S NAME (Type)  |      |   | 22e. ADDRESS   |  |                        |                                   |  |
| <u>Israel D. Weiner, M.D.</u>   |  |  | 2/29/68  |  |                                    | ISRAEL WEINER   |      |   | 6222 WOODCREST AVENUE  |  |                        |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |      | 23d. LOCATION (City or Town) (County) (State) |  |  |                        |                                   |  |
| BURIAL  |  |  | 3-1-68   |  | BETH TFILOH                        |   |      | BALTIMORE MARYLAND                            |  |  |                        |                                   |  |
| 24. FUNERAL DIRECTOR  |  |  | ADDRESS  |  |                                    | 25a. REC'D BY REGISTRAR   |      |   | 25b. REGISTRAR'S SIGNATURE   |  |                        |                                   |  |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN   |  |  | ROAD   |  |                                    | MAR 5 1968  |      |   | <u>Richard J. J...</u>   |  |                        |                                   |  |

02130

02130

02130

ST. LOUIS

GLASS

J.

FEBRUARY 19, 1933

ALC

WILLI

SEPT. 12, 1933

U.S.A.

COURT ROAD

PIKEVILLE

GREEN ROAD WAY & GIN

PHYSICIAN

PIKEVILLE

BALTIMORE

GREEN ROAD WAY

STON

GLASS

JENNIE

STON

MISS. ALICE CLARK, GREEN ROAD WAY & GIN

MISS. ALICE CLARK, GREEN ROAD WAY & GIN

MISS. ALICE CLARK, GREEN ROAD WAY & GIN

MISS. ALICE CLARK, GREEN ROAD WAY & GIN

MISS. ALICE CLARK, GREEN ROAD WAY & GIN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02197

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02186

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>WILLIAM AUGUST GOENNER, JR.</i>   |  |   | 2a. DATE OF DEATH<br><i>2</i> Month <i>20</i> Day <i>1968</i> Year  |   | 2b. HOUR<br>M  |
| 3. SEX<br><i>M</i>   | 4. RACE<br><i>W</i>  | 5. DATE OF BIRTH<br><i>3-19-1888</i>  |   | 6. AGE (In years last birthday)<br><i>79</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><i>MARYLAND</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><i>BALTIMORE</i> Md.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTIMORE</i>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>ARMACOST NURSING HOME</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>PAINTER</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>PAINTING.</i>            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>MARYLAND</i>   | 13b. COUNTY<br><i>BALT</i>   | 13c. CITY OR TOWN<br><i>BALTIMORE</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 13e. STREET AND NUMBER<br><i>521 N. STREEPER ST.</i>  |  |
| 14. FATHER'S NAME First Middle Last<br><i>WILLIAM AUGUST GOENNER SR.</i>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>MARY GEPHART.</i>  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><i>-</i>  |   | 17. INFORMANT<br><i>Mrs. Amelia M. Goenner - 521 N. Streper Cr.</i> Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><i>1991</i> IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1972</i> (b) <i>carcinoma? etiology</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>arteriosclerotic cardiovascular disease</i>   |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><i>none</i>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>none</i>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                           |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2/15</i> , 19 <i>68</i> , to <i>2/20</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2/19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                           |  |   |   |   |  |
| 22b. SIGNATURE<br><i>Alan Tapper M.D.</i>  |  |   | DEGREE  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><i>2/21/68</i>                               |
| 22d. PHYSICIAN'S NAME (Type)<br><i>ALAN TAPPER M.D.</i>  |  |   | 22e. ADDRESS<br><i>7501 YORK RD. TOWSON MD.</i>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   | 23b. DATE<br><i>2-23-68</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>LORRAINE PARK MASOLEUM.</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>BALTO. MD.</i>  |  |
| 24. FUNERAL DIRECTOR<br><i>Charles Judge - 2334 Jefferson St.</i>  |  |   | ADDRESS   | 25a. REC'D BY REGISTRAR<br>DATE <i>FEB 23 1968</i>  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>               |

48130

10130



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02198   |  |  |  |  |  |  |  |  |  | 02187  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR   |  |  |  |  |
| Thomas  |  |  |  |  | E. Good  |  |  |  |  | February 9 1968  |  |  |  |  | M  |  |  |  |  |
| 3. SEX  |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years lost birthday)  |  |  |  |  |
| Male  |  |  |  |  | White  |  |  |  |  | July 11, 1880  |  |  |  |  | 87 YRS.  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |
| Pennsylvania  |  |  |  |  | U. S. A.   |  |  |  |  |  |  |  |  |  | Baltimore Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |
| Edgemere  |  |  |  |  | 7319 North Dakota Ave.   |  |  |  |  | Retired Labor Work   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |
| Maryland  |  |  |  |  | Baltimore  |  |  |  |  | Edgemere   |  |  |  |  | 7319 North Dakota Ave.   |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Jacob   |  |  |  |  | Good   |  |  |  |  | Sarah  |  |  |  |  | Anderson   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT (Son)  |  |  |  |  | Address Md. 21219  |  |  |  |  |
| No  |  |  |  |  | 218-03-9035  |  |  |  |  | Mr. William J. Good, Todd Ave. Ft. Howard,   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Gastrointestinal Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |
| 5699  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 1 HR   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>5788</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 12, 1960, to Feb 9, 1968, that (I) (we) last saw the deceased alive on Feb 7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE John V. Conway M.D.  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 2-12-68   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) John V. Conway M.D.  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 914 "D" Street, Sparrows Pt. Md. 21219  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |
| Burial  |  |  |  |  | 2/13/68  |  |  |  |  | Bel Air Memorial Gardens   |  |  |  |  | Bel Air Md.  |  |  |  |  |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE FEB 14 1968   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |

MEDICAL CERTIFICATION

02187

CERTIFICATE OF DEATH

02187

|                        |  |                        |  |                           |  |                           |  |                             |  |
|------------------------|--|------------------------|--|---------------------------|--|---------------------------|--|-----------------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                       |  | Date of Birth             |  | Place of Birth              |  |
| John Doe               |  | Male                   |  | 45                        |  | 1930                      |  | New York, N.Y.              |  |
| Cause of Death         |  | Manner of Death        |  | Occupation                |  | Education                 |  | Religion                    |  |
| Heart Disease          |  | Natural                |  | Teacher                   |  | High School               |  | Catholic                    |  |
| Physician              |  | Hospital               |  | Funeral Home              |  | Burial Place              |  | Date of Burial              |  |
| Dr. Smith              |  | St. Mary's             |  | Doe & Sons                |  | St. Mary's Cemetery       |  | 1975                        |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Funeral Home |  | Signature of Burial Place |  | Signature of Date of Burial |  |
| [Signature]            |  | [Signature]            |  | [Signature]               |  | [Signature]               |  | [Signature]                 |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |                                  |  |                 |  |         |                             |  |
|--|--|--|----------------------------------|--|-----------------|--|---------|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |                                  |  |                 |  |         |                             |  |
| CERTIFICATE OF DEATH   |  |  |                                  |  |                 |  |         |                             |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last                |  |                 | 2a. DATE OF DEATH  |         | 2b. HOUR                    |  |
| Charles T. Goodwin   |  |  |                                  |  |                 | Month Day Year<br>Feb. 17 1968   |         | 8:40 PM                     |  |
| 3. SEX   |  | 4. RACE  |                                  | 5. DATE OF BIRTH   |                 | 6. AGE (In years lost birthday)  |         | IF UNDER 1 YEAR MONTHS DAYS |  |
| male   |  | white  |                                  | Oct. 24, 1894  |                 | 73 YRS.  |         |                             |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                 | 9. COUNTY OF DEATH   |         | Md.                         |  |
| Maryland   |  | USA  |                                  |  |                 | Baltimore  |         |                             |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |                 | 12b. KIND OF BUSINESS OR INDUSTRY  |         |                             |  |
| Baltimore 21234  |  | 8706 Edgefield Road  |                                  | Maritime Watchman  |                 |  |         |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |                                  | 13c. CITY OR TOWN  |                 | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |         | 13e. STREET AND NUMBER      |  |
| Md.  |  | Baltimore  |                                  | Balto. 34  |                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |         | 8706 Edgefield Road         |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME         |  |                 |  |         |                             |  |
| First Middle Last<br>Charles T. Goodwin  |  |  | First Middle Last<br>Mary Fraley |  |                 |  |         |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes, give year or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.         |  | 17. INFORMANT   |  | Address |                             |  |
| yes WW I   |  |  | 219129688                        |  | Blanche Goodwin |  | same    |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Arteriosclerotic Cardiovascular Disease   |  |  |                                  |  |                 |  |         |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| - DUE TO, OR AS A CONSEQUENCE OF -   |  |  |                                  |  |                 |  |         |                             |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) = With Coronary Insufficiency   |  |  |                                  |  |                 |  |         |                             |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF + accompanied by Cerebro Vascular Insufficiency   |  |  |                                  |  |                 |  |         |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4301 Old Cerebrovascular occlusion with partial Hemiparesis   |  |  |                                  |  |                 |  |         |                             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |         |                             |  |
|  |  |  |                                  |  |                 |  |         |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                 |  |         |                             |  |
|  |  |  |                                  |  |                 |  |         |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                                  | 21f. LOCATION Street or R.F.D. No.   |                 | City or Town   |         | County State                |  |
|  |  |  |                                  |  |                 |  |         |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1966, to Feb 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                                  |  |                 |  |         |                             |  |
| 22b. SIGNATURE Frank Rask Jr   |  |  |                                  |  |                 | 22c. DATE SIGNED 2/18/68   |         |                             |  |
| 22d. PHYSICIAN'S NAME (Type) FRANK T. RASK JR  |  |  |                                  |  |                 | 22e. ADDRESS 9005 Harford Rd   |         | Baltimore                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |                                  | 23c. NAME OF CEMETERY OR CREMATORY   |                 | 23d. LOCATION (City or Town) (County) (State)  |         |                             |  |
| burial   |  | 2-20-68  |                                  | Glen Haven Cemetery  |                 | Glen Burnie, Md.   |         |                             |  |
| 24. FUNERAL DIRECTOR   |  |  |                                  |  |                 | 25a. REC'D BY REGISTRAR  |         | 25b. REGISTRAR'S SIGNATURE  |  |
| Leonard J. Ruck, Inc Baltimore, Md.  |  |  |                                  |  |                 | FEB 19 1968  |         | Charles Judge               |  |

Handwritten notes at the top of the page, including the number 03188 and some illegible text.

Handwritten notes in the middle section, including the number 03188 and some illegible text.

Handwritten notes at the bottom of the page, including the number 03188 and some illegible text.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-43. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02200

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02189

|  |         |                              |   |   |          |  |          |                          |   |     |  |          |
|--|---------|------------------------------|---|---|----------|--|----------|--------------------------|---|-----|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First   | Middle  | Lost     | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED  |          |                          | Month   | Day | Year   | 2b. HOUR |
| George   |         |                              | Howard  |   | Grinnell | Jr.  | February |                          |   | 13  | 1968   | 4:45 PM  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years<br>lost birthday)  | IF UNDER 1 YEAR   |          | IF UNDER 24 HRS.   |          | 2c. DATE PRONOUNCED DEAD |   |     | 2d. HOUR   |          |
| Male   | Cau.    | July 29, 1911                | 56 YRS.   | MONTHS  | DAYS     | HOURS  | MIN.     | February 13              |   |     | 1968 4:45 PM   |          |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. COUNTY OF DEATH   |          |                          | Md.   |     |  |          |
| Brockton, Mass   |         | USA                          |   |   |          | Baltimore  |          |                          |   |     |  |          |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |          | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |          |                          | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |     |  |          |
| Lutherville  |         |                              | 7 Picket Rd.  |   |          | Writer   |          |                          | Steel   |     |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         |                              | 13b. COUNTY   |   |          | 13c. CITY OR TOWN  |          |                          | 13d. INSIDE CITY LIMITS?  |     |  |          |
| Md.  |         |                              | Balto.  |   |          | Lutherville  |          |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |     |  |          |
| 13e. STREET AND NUMBER   |         |                              | 13f. CITY OR TOWN   |   |          | 13g. INSIDE CITY LIMITS?   |          |                          | 13h. STREET AND NUMBER  |     |  |          |
| 7 Picket Rd.   |         |                              | 21093   |   |          |  |          |                          |   |     |  |          |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME  |   |          | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)                       |          |                          | 16b. SOCIAL SECURITY NO.  |     |  |          |
| George   |         |                              | Emma Hamilton   |   |          | No   |          |                          | 112-10-9195   |     |  |          |
| 17. INFORMANT  |         |                              | 17. ADDRESS   |   |          | 17. ADDRESS  |          |                          | 17. ADDRESS   |     |  |          |
| George H. Grinnell III   |         |                              | Same  |   |          |  |          |                          |   |     |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carbon Monoxide Intoxication</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |         |                              |   |   |          |  |          |                          |   |     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Sudden</u> |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |                              |   |   |          |  |          |                          |   |     |  |          |
| 9731   |         |                              |   |   |          |  |          |                          |   |     |  |          |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |   |          | 20. AUTOPSY?   |          |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |     |  |          |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____<br>P.M. 19              |   |          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |          |                          |   |     |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |         |                              | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |   |          | 21f. LOCATION Street or R.F.D. No. _____   |          |                          | City or Town _____ County _____ State _____                         |     |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |   |   |          |  |          |                          |   |     |  |          |
| ACTUAL<br>SIGNATURE <u>Charles F. O'Donnell</u>  |         |                              | M.D.  |   |          | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |          |                          | 22b. DATE SIGNED  |     |  |          |
| EXAMINER'S<br>NAME (Type) Charles F. O'Donnell   |         |                              |   |   |          | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |          |                          | 2/13/68   |     |  |          |
|  |         |                              |   |   |          | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                |          |                          | ADDRESS (Street, city, town, or county)                             |     |  |          |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         |                              | 23b. DATE   |   |          | 23c. NAME OF CEMETERY OR CREMATORY   |          |                          | 23d. LOCATION (City or Town) (County) (State)                       |     |  |          |
| Burial   |         |                              | 2-16-1968   |   |          | Prospect Hill  |          |                          | Blato, Md. 21204  |     |  |          |
| 24. FUNERAL DIRECTOR   |         |                              | ADDRESS   |   |          | 25a. REC'D BY REGISTRAR  |          |                          | 25b. REGISTRAR'S SIGNATURE  |     |  |          |
| Wm. Cook-Brooks Towson 1050 York Rd. Towson, Md  |         |                              |   |   |          | FEB 16 1968  |          |                          | [Signature]   |     |  |          |

02180

02180

833 81 371

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |                                   |  |  |
|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|
| 02201  |  |  |  |  |  | 02190  |  |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR                          |  |  |
| John P.M.  |  |  | HAAS, JR   |  |  | February 1 68  |  |  | M                                 |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |                                   | IF UNDER 24 HRS.                             |  |
| Male   |  | White  |  | Dec 30, 1883   |  | 84 YRS.  |  | MONTHS DAYS  |                                   | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |                                   |  |  |
| Lukens, PA   |  | U.S.A.   |  |  |  | Baltimore Md.  |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| HARRISONVILLE  |  |  | Chapel Hill Nursing Home   |  |  | Gas & Electric Co  |  |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Md   |  |  | Balto  |  |  | BALTO  |  | YES  |                                   | 4604 Springdale Ave                          |  |
| 14. FATHER'S NAME First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |                                   |  |  |
| John P.M. HAAS SR  |  |  | UNKNOWN  |  |  |  |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  |                                   |  |  |
| No   |  |  |  |  |  | Edwin K HAAS - 3685 Monroe Ave Pittsford New York  |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4379 Cerebral arteriosclerosis   |  |  |  |  |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |  |  |  |  |                                   | 4 yrs.                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |                                   |  |  |
| 334 X  |  |  |  |  |  |  |  |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
|  |  |  |  |  |  |  |  |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |                                   |  |  |
|  |  |  |  |  |  |  |  |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |                                   |  |  |
|  |  |  |  |  |  |  |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1966, to Feb. 1, 1968, that (I) (we) last saw the deceased alive on Jan. 31, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |                                   |  |  |
| 22b. SIGNATURE Marvin Goldstein  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED 2/2/68  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN  |  |  |  |  |  | 22e. ADDRESS 6001 PARK HEIGHTS AVE. BALTO, MD.   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |                                   |  |  |
| Burial   |  | 2-5-68   |  | Glenwood Cemetery  |  | Washington, D.C.   |  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost-4600 Liberty Apts Ave  |  |  |  |  |  | 25a. RECEIVED BY REGISTRAR DATE Feb 5 1968   |  | 25b. REGISTRAR'S SIGNATURE   |                                   |  |  |

MEDICAL CERTIFICATION

00150

UNITED STATES DEPARTMENT OF AGRICULTURE

1933

10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02202  |  |  |  |  |  |  |  |  |  | 02191  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR   |  |  |  |  |                            |  |  |  |  |
| Julia  |  |  |  |  | G. Hamlin  |  |  |  |  | Feb. 26 1968   |  |  |  |  | M  |  |  |  |  |                            |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |                            |  |  |  |  |
| Female   |  |  |  |  | White  |  |  |  |  | Jan. 30, 1882  |  |  |  |  | 86 YRS.  |  |  |  |  |                            |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |                            |  |  |  |  |
| Minn.  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | Baltimore Md.  |  |  |  |  |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                            |  |  |  |  |
| Randalstown  |  |  |  |  | Chapel Hill Nursing Ho.  |  |  |  |  | Housewife  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |                            |  |  |  |  |
| Md.  |  |  |  |  |  |  |  |  |  | Balto.   |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  |  |                            |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  | 13e. STREET AND NUMBER   |  |  |  |  | 21215  |  |  |  |  |                            |  |  |  |  |
| Haram Parke Hamlin   |  |  |  |  | Minnie Dwinell   |  |  |  |  | 3617 Spalding Ave  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address  |  |  |  |  |                            |  |  |  |  |
|  |  |  |  |  | 220-48-8465  |  |  |  |  | Mrs. Jane G. Brooks  |  |  |  |  | 3617 Spalding Ave  |  |  |  |  |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 CORONARY INFARCTION   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS.  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD.  |  |  |  |  |  |  |  |  |  | 10 YRS   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 4201   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |                            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 2-26 1968 to 2-26 1968, that (I) (we) last saw the deceased alive on 2-26 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 11:30 A.M. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 22b. SIGNATURE R.V. Houck, Jr. M.D. DEGREE   |  |  |  |  |  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  |  |  | 22c. DATE SIGNED 2-27-68   |  |  |  |  |                            |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) R.V. Houck, Jr.   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS Liberty Rd. Sykesville, Md.   |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                            |  |  |  |  |
| Burial   |  |  |  |  | 2/29/1968  |  |  |  |  | Woodlawn   |  |  |  |  | Baltimore Md.  |  |  |  |  |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |
| Harry H. Arnason   |  |  |  |  |  |  |  |  |  | 4204 Ridgewood Cir   |  |  |  |  | DATE FEB 29 1968   |  |  |  |  | James J. Jones             |  |  |  |  |

05181

INSTITUTE OF DESIGN

05300

INSTITUTE OF DESIGN

05181

05300



INSTITUTE OF DESIGN

INSTITUTE OF DESIGN

INSTITUTE OF DESIGN

INSTITUTE OF DESIGN

INSTITUTE OF DESIGN

INSTITUTE OF DESIGN

INSTITUTE OF DESIGN

INSTITUTE OF DESIGN

INSTITUTE OF DESIGN

INSTITUTE OF DESIGN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02203   |  |  |           |  |  |                  |  |  |                                 | 02192  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
|---|--|--|-----------|--|--|------------------|--|--|---------------------------------|--|--|------------------------|--|--|--|--|--|--|--|----------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |           |  |  |                  |  |  |                                 | CERTIFICATE OF DEATH   |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |           |  | First Middle Last  |                  |  |  |                                 | 2a. DATE OF DEATH  |  |                        |  |  | 2b. HOUR P   |  |  |  |  |                            |  |  |  |  |
| SADIE   |  |  |           |  | OLIVIA   |                  |  |  |                                 | HAMPSHIRE  |  |                        |  |  | 2 Month 12 Day 68 Year 11:10 M   |  |  |  |  |                            |  |  |  |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH |  |  | 6. AGE (In years lost birthday) |  |  | IF UNDER 1 YEAR        |  |  | IF UNDER 24 HRS.   |  |  |  |  |                            |  |  |  |  |
| Female  |  |  | Caucasian |  |  | Jan. 15, 1888    |  |  | 80 YRS.                         |  |  | MONTHS DAYS HOURS MIN. |  |  |  |  |  |  |  |                            |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |           |  | 7b. CITIZEN OF WHAT COUNTRY?   |                  |  |  |                                 | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                        |  |  | 9. COUNTY OF DEATH   |  |  |  |  |                            |  |  |  |  |
| Maryland  |  |  |           |  | U.S.A.   |                  |  |  |                                 |  |  |                        |  |  | Baltimore Md.  |  |  |  |  |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |           |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |  |  |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |                        |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |                            |  |  |  |  |
| Towson, Maryland  |  |  |           |  | Greater Balto. Med. Center   |                  |  |  |                                 | Housewife  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |           |  | 13b. COUNTY  |                  |  |  |                                 | 13c. CITY OR TOWN  |  |                        |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER     |  |  |  |  |
| Maryland  |  |  |           |  |  |                  |  |  |                                 | Baltimore  |  |                        |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  |  | 4507 Glen Arm Ave          |  |  |  |  |
| 14. FATHER'S NAME   |  |  |           |  | 15. MOTHER'S MAIDEN NAME   |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| Philip  |  |  |           |  | Boulden  |                  |  |  |                                 | Susanna  |  |                        |  |  | R  |  |  |  |  | Collins                    |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  |           |  | 16b. SOCIAL SECURITY NO.   |                  |  |  |                                 | 17. INFORMANT  |  |                        |  |  | Address  |  |  |  |  |                            |  |  |  |  |
| No  |  |  |           |  |  |                  |  |  |                                 | Mr Lynwood F Hampshire   |  |                        |  |  | 2920 Chesley Ave   |  |  |  |  |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |                            |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| IMMEDIATE CAUSE (a) Hemomediastinum and left hemothorax   |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 441.1 DUE TO, OR AS A CONSEQUENCE OF  |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| (b) Ruptured dissection of thoracic aorta   |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| (c)   |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 451X  |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |           |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |  |  |                                 | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                        |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes                     |  |  |  |  |                            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |           |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                  |  |  |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |           |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                  |  |  |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/12, 1968, to 2/12, 1968, that (I) (we) last saw the deceased alive on 2/12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |           |  |  |                  |  |  |                                 |  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 22b. SIGNATURE  |  |  |           |  |  |                  |  |  |                                 | 22c. DATE SIGNED   |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| John E. Adams   |  |  |           |  |  |                  |  |  |                                 | Feb. 13, 1968  |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |           |  |  |                  |  |  |                                 | 22e. ADDRESS   |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| JOHN E. ADAMS, M.D.   |  |  |           |  |  |                  |  |  |                                 | Greater Baltimore Medical Center   |  |                        |  |  |  |  |  |  |  |                            |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |           |  | 23b. DATE  |                  |  |  |                                 | 23c. NAME OF CEMETERY OR CREMATORY   |  |                        |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |                            |  |  |  |  |
| Burial  |  |  |           |  | 2/16/68  |                  |  |  |                                 | Grace Methodist  |  |                        |  |  | Black Rock Md  |  |  |  |  |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |           |  |  |                  |  |  |                                 | 25a. REC'D BY REGISTRAR  |  |                        |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |
| Leonard J Ruck Inc Baltimore, Maryland  |  |  |           |  |  |                  |  |  |                                 | DATE FEB 15 1968   |  |                        |  |  |  |  |  |  |  | Fuentes Judge              |  |  |  |  |

03180

03330

THURSDAY

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
|---|--|---------|------------------------------|--|--|--|---------------------------------|---|--------------------|--|------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |         | First Middle Last            |  |  | 2a. DATE OF DEATH  |                                 |   | 2b. HOUR           |  |                  |  |  |  |  |
| Ira   |  |         | Leabelle Handwerker          |  |  | February 5 1968  |                                 |   | M                  |  |                  |  |  |  |  |
| 3. SEX  |  | 4. RACE |                              | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday) |   | IF UNDER 1 YEAR    |  | IF UNDER 24 HRS. |  |  |  |  |
| Female  |  | White   |                              | January 30 1875  |  |  | 98 YRS.                         |   | MONTHS DAYS        |  | HOURS MIN.       |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY? |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |   | 9. COUNTY OF DEATH |  |                  |  |  |  |  |
| Md.   |  |         | U.S.                         |  |  |  |                                 |   | Baltimore          |  |                  | Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |                                 | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                    |  |                  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |
| Coe Keyserville   |  |         |                              | Md. Masonic Home   |  |  |                                 | Housewife   |                    |  |                  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         |                              | 13b. COUNTY  |  |  |                                 | 13c. CITY OR TOWN   |                    | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                  | 13e. STREET AND NUMBER   |  |  |  |
| Md  |  |         |                              | -  |  |  |                                 | Baltimore   |                    |  |                  | 3604 Mohawk Ave  |  |  |  |
| 14. FATHER'S NAME   |  |         | First Middle Last            |  |  | 15. MOTHER'S MAIDEN NAME   |                                 |   | First Middle Last  |  |                  |  |  |  |  |
| Valentine   |  |         | Cook                         |  |  | Martha   |                                 |   | Bailey             |  |                  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service)  |  |         |                              | 16b. SOCIAL SECURITY NO.   |  |  |                                 | 17. INFORMANT   |                    |  |                  | Address  |  |  |  |
| No  |  |         |                              | 058-09-7102D   |  |  |                                 | Records of Md Masonic Home  |                    |  |                  | Coe Keyserville Md   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |                              |  |  |  |                                 |   |                    |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |  |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| 4109 Coronary artery occlusion  |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| Cerebral arteriosclerosis   |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| Marked Senility   |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| 4201  |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |                                 | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                    |  |                  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|   |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |         |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                    |  |                  |  |  |  |  |
|   |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>  |  |         |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                    |  |                  |  |  |  |  |
|   |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 15, 1965, to Feb 5, 1968, that (I) (we) last saw the deceased alive on Feb 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 4-15 AM 2/5/68. |  |         |                              |  |  |  |                                 |   |                    |  |                  |  |  |  |  |
| 22b. SIGNATURE  |  |         |                              |  |  |  |                                 | 22c. DATE SIGNED  |                    |  |                  |  |  |  |  |
| JAMES H. HAMED MD. DEGREE   |  |         |                              |  |  |  |                                 | 2/5/68  |                    |  |                  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |         |                              |  |  |  |                                 | 22e. ADDRESS  |                    |  |                  |  |  |  |  |
| JAMES H. HAMED MD.  |  |         |                              |  |  |  |                                 | MASONIC HOME, COEKEYSVILLE MD.  |                    |  |                  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         |                              | 23b. DATE  |  |  |                                 | 23c. NAME OF CEMETERY OR CREMATORY  |                    |  |                  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |  |
| BURIAL  |  |         |                              | Feb. 6 1968  |  |  |                                 | Herbrew Friendship  |                    |  |                  | BALTIMORE, MD.   |  |  |  |
| 24. FUNERAL DIRECTOR  |  |         |                              |  |  |  |                                 | 25a. REC'D BY REGISTRAR   |                    |  |                  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Wm. Cook-Brooks Towson  |  |         |                              |  |  |  |                                 | FEB 9 1968  |                    |  |                  | Charles Judge  |  |  |  |

35133

0330



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                              |  |  |      |   |      |                          |   |  |          |
|---|---------|------------------------------|--|--|------|---|------|--------------------------|---|--|----------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |                              |  |  |      |   |      |                          |   |  |          |
| 1. DECEASED-NAME (Type or Print)  |         |                              | First Middle Last  |  |      | 2a. DATE KNOWN OF DEATH   |      |                          | 2b. HOUR                                      |  |          |
| Cassander - HARDY   |         |                              |  |  |      | 2. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year   |      |                          | 2b. HOUR 5:30                                 |  |          |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS.  |      | 2c. DATE PRONOUNCED DEAD |   |  | 2d. HOUR |
| FeMale  | Negro   | 11/19/57                     | 10 YRS.  | MONTHS   | DAYS | HOURS   | MIN. | Month Day Year           |   |  | 5:30     |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH  |      |                          |   |  |          |
| Maryland  |         | U.S.A.                       |  |  |      | Baltimore Md.   |      |                          |   |  |          |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |      |                          | 12b. KIND OF BUSINESS OR INDUSTRY             |  |          |
| Owings Mills  |         |                              | Rosewood State Hospital  |  |      | Dependent   |      |                          | none  |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. COUNTY  |  |      | 13c. CITY OR TOWN   |      |                          | 13d. INSIDE CITY LIMITS?                      |  |          |
| Md.   |         |                              | Baltimore  |  |      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |      |                          | 13e. STREET AND NUMBER                        |  |          |
|   |         |                              |  |  |      |   |      |                          | 1335 East North Avenue                        |  |          |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME   |  |      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |      |                          | 16b. SOCIAL SECURITY NO.                      |  |          |
| William - Thomas  |         |                              | Helen Maxine Hardy   |  |      | no  |      |                          | none  |  |          |
| 17. INFORMANT   |         |                              | ADDRESS  |  |      | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |      |                          |   |  |          |
| Rosewood Records, Owings Mills, Maryland  |         |                              |  |  |      | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia  |      |                          |   |  |          |
|   |         |                              |  |  |      | DUE TO, OR AS A CONSEQUENCE OF  |      |                          |   |  |          |
|   |         |                              |  |  |      | (b) Fractured Left Humerous   |      |                          |   |  |          |
|   |         |                              |  |  |      | DUE TO, OR AS A CONSEQUENCE OF  |      |                          |   |  |          |
|   |         |                              |  |  |      | (c) Epilepsy - Spastic Quadriplegia   |      |                          |   |  |          |
|   |         |                              |  |  |      | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |      |                          |   |  |          |
| 19a. DATE OF OPERATION  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |      | 20. AUTOPSY?  |      |                          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |          |
|   |         |                              |  |  |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |      |                          | 10 days                                       |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH   |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |                          |   |  |          |
|   |         |                              | 1:30 P.M. 2/19 19 68?  |  |      | Unknown   |      |                          |   |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK   |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |      | 21f. LOCATION Street or R.F.D. No. City or Town County State  |      |                          |   |  |          |
|   |         |                              | Wyse I Cottage   |  |      | Rosewood St. Hosp., Owings Mills, Balto. Md.  |      |                          |   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |      |   |      |                          |   |  |          |
| ACTUAL SIGNATURE  |         |                              | CHIEF MEDICAL EXAMINER   |  |      | ASSISTANT MEDICAL EXAMINER  |      |                          | 22b. DATE SIGNED                              |  |          |
| D. D. Caples  |         |                              |  |  |      |   |      |                          | 3/4/68  |  |          |
| EXAMINER'S NAME (Type)  |         |                              | DEPUTY MEDICAL EXAMINER  |  |      | ADDRESS (Street, city, town, or county)   |      |                          | Reisterstown, Md.                             |  |          |
| D. D. Caples, M.D.  |         |                              |  |  |      |   |      |                          |   |  |          |
| 23a. BURIAL, CREMATION, or other disposal (Specify)   |         |                              | 23b. DATE  |  |      | 23c. NAME OF CEMETERY OR CREMATORY  |      |                          | 23d. LOCATION (City or Town) (County) (State) |  |          |
| Burial  |         |                              | 3/6/68   |  |      | Rosewood Cemetery   |      |                          | Owings Mills, Md.                             |  |          |
| 24. FUNERAL DIRECTOR  |         |                              |  |  |      | ADDRESS   |      |                          | 25a. REC'D BY REGISTRAR                       |  |          |
| J. F. Eline & Sons Reisterstown, Md.  |         |                              |  |  |      |   |      |                          | DATE MAR 8 1968                               |  |          |
|   |         |                              |  |  |      |   |      |                          | 25b. REGISTRAR'S SIGNATURE                    |  |          |
|   |         |                              |  |  |      |   |      |                          |   |  |          |

20530

4394

00000000

†continued

3. *St. Louis*

mailing

2000

3

[illegible]

Unknown

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02206  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 02194   |  |  |  |  |  |   |  |                  |  |
|--|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|------------------|--|
| Items 13 c & 13e Film 4397 2/19/68   |  |  |  | CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  |   |  |                  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>Agnes   |  | Middle<br>Gertrude   |  | Last<br>HARTMAIER  |  | 2a. DATE OF DEATH<br>Month<br>2   |  | Day<br>6   |  | Year<br>68   |  | 2b. HOUR<br>6:00P <sup>M</sup>                                      |  |                  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>April 21, 1881   |  | 6. AGE (In years<br>last birthday)<br>86   |  | 7. AGE (In years<br>last birthday)<br>86  |  | 8. AGE (In years<br>last birthday)<br>86   |  | 9. COUNTY OF DEATH<br>Baltimore County   |  | 10. AGE (In years<br>last birthday)<br>86                           |  |                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Missouri   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH<br>Baltimore County   |  | 10. CITY OR TOWN OF DEATH<br>Mount Wilson                                       |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Mt. Wilson State Hospital |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Balto   |  | 13c. CITY OR TOWN<br>Towson  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br>1819 Swansea Rd.                                      |  | 13f. STREET AND NUMBER<br>Stelle Marie Hospice   |  | 13g. STREET AND NUMBER<br>Stelle Marie Hospice   |  | 13h. STREET AND NUMBER<br>Stelle Marie Hospice                      |  |                  |  |
| 14. FATHER'S NAME<br>First<br>Richard  |  | Middle<br>Hartmaier  |  | Last<br>Diven  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Marie   |  | Middle<br>Diven   |  | Last<br>Diven  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No  |  | 16b. SOCIAL SECURITY NO.<br>490-16-5778                             |  |                  |  |
| 17. INFORMANT<br>Address<br>Records, Mt. Wilson State Hospital   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Rheumatic Heart Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. <u>4/16/68</u> |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Pulmonary Fibrosis and Emphysema associated with Tuberculosis</u> |  | 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br>Yes   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                     |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner) |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  | 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  | 22a. I certify that (I) (this hospital) attended the deceased from Jan. 25, 1968, to Feb. 6, 1968, that (I) (we) last<br>saw the deceased alive on Feb. 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>William Newcomer</u>                           |  | 22c. DATE SIGNED |  |
| 22d. PHYSICIAN'S<br>NAME (Type) William Newcomer, M.D.   |  | 22e. ADDRESS<br>Mount Wilson, Maryland   |  | 23a. REC'D BY REGISTRAR<br>DATE FEB 13 1968  |  | 23b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery                    |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.  |  | 23e. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23f. DATE<br>2/10/68  |  |                  |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 13 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>   |  | 25c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cemetery   |  | 25d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                 |  | 25e. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 25f. DATE<br>2/10/68   |  | 25g. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson 1050 York Rd. 21204 |  |                  |  |

03130

03130

03130 03130 03130

03130 03130 03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

03130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |  |   |   |  |                                |   |                                |  |
|--|--|--|--|--|---|---|--|---|---|--|--------------------------------|---|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |   |   |  |                                |   |                                |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |   |   |  |                                |   |                                |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>FRANCES   |  | Middle<br>M.  |   | Last<br>HARTZELL   |   | 2a. DATE OF DEATH<br>February 19 1968                                   |  |                                | 2b. HOUR<br>4:30 PM                             |                                |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>White   |  |   | 5. DATE OF BIRTH<br>October 7, 1903   |  |   | 6. AGE (In years<br>last birthday)<br>64 YRS.                           |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH<br>Baltimore Md.                                     |  |                                |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Joseph Hospital |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |  |                                |   |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |  |  | 13b. COUNTY<br>Baltimore   |  |   | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>28 Dunvale Rd. |                                |   |                                |  |
| 14. FATHER'S NAME First Middle Last<br>Francis X. Milholland   |  |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary Loretta Osing  |  |   |   |  |                                |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) no  |  |  | 16b. SOCIAL SECURITY NO.<br>B-705-03-4795  |  |   | 17. INFORMANT<br>Andrew C. Hartzell   |  |   | Address<br>24 Dunvale Rd. #4  |  |                                |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho-pneumonia left lower lobe</u><br>4319 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive intra-cerebral hemorrhage.</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |  |   |   |  |   |   |  |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>331X   |  |  |  |  |   |   |  |   |   |  |                                |   |                                |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |                                |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |   | County                                   |                                | State   |                                |  |
| 22a. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>February 15 1968</u> , to <u>February 19 1968</u> , that <u>(I)</u> (we) last<br>saw the deceased alive on <u>February 19 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |  |   |   |  |   |   |  |                                |   |                                |  |
| 22b. SIGNATURE<br><u>Lawrence F. Misanik</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |  |   |   |  |   | 22c. DATE SIGNED<br>February 20, 1968                                   |  |                                |   |                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Lawrence F. Misanik, M.D.   |  |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204   |  |   |   |  |   |   |  |                                |   |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>burial   |  |  | 23b. DATE<br>2/22/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral |   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |   |  |                                |   |                                |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Mitchell-Wiedefeld Home 6500 York Rd.<br>Balto., Md. 21212  |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>FEB 26 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>    |   |  |   |   |  |                                |   |                                |  |

02132

02501

02501

101

x

101

02501

02501



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02208   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02196  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Theresa   |  |  |  |  |  |  |  |  |  | O.   |  |  |  |  |  |  |  |  |  | Hayner   |  |  |  |  |  |  |  |  |  | Month 2 Day 3 Year 68 11:20 PM   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |  |  |  |  |  |  |
| Fem.  |  |  |  |  |  |  |  |  |  | Caus   |  |  |  |  |  |  |  |  |  | 7-21-1878  |  |  |  |  |  |  |  |  |  | 89 YRS.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Poland  |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Balto.   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Catonsville   |  |  |  |  |  |  |  |  |  | 1329 Middle Ford Rd.   |  |  |  |  |  |  |  |  |  | Housewife  |  |  |  |  |  |  |  |  |  | Home   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Md  |  |  |  |  |  |  |  |  |  | Balto.   |  |  |  |  |  |  |  |  |  | Catonsville  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 1329 Middle Ford Rd         |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | ?  |  |  |  |  |  |  |  |  |  | Olechnowicz  |  |  |  |  |  |  |  |  |  | ?  |  |  |  |  |  |  |  |  |  | ?                           |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  |  |  |  |  |  | 094-16-8401  |  |  |  |  |  |  |  |  |  | Mrs. David Pius  |  |  |  |  |  |  |  |  |  | Same   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)                             |  |  |  |  |  |  |  |  |  | 4120   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  | Acute Pulmonary Edema -  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  | Congestive Heart Failure   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  | Hypertensive Cardiovascular Disease  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c)  |  |  |  |  |  |  |  |  |  | 443X   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-2, 1968, to 2-3, 1968, that (I) (we) last saw the deceased alive on 2-3, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Domingo   |  |  |  |  |  |  |  |  |  | 2-3-68   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| DOMINGO C. SORONGON M.D.  |  |  |  |  |  |  |  |  |  | 3915 HOLCINS FERRY RD. BALTIMORE, MD 21227                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Removal   |  |  |  |  |  |  |  |  |  | 2-4-1968   |  |  |  |  |  |  |  |  |  | Lesczynski Fun. Home   |  |  |  |  |  |  |  |  |  | Schenectady, N.Y.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Wm. Cook-Brooks, Inc.   |  |  |  |  |  |  |  |  |  | 12175 Paul St. Balto., Md. 21202   |  |  |  |  |  |  |  |  |  | DATE FEB 6 1968  |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |

4336

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>CHARLES</b>   |  |  | Middle<br><b>D.</b>   |  |  | Last<br><b>HEARD</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>26</b> Year <b>68</b> |  |  | 2b. HOUR<br><b>6:30A</b> M                         |  |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br><b>4/30/92</b>  |  |  | 6. AGE (In years last birthday)<br><b>75</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS <b>15</b> DAYS <b>15</b>               |  |  | IF UNDER 24 HRS.<br>HOURS <b>15</b> MIN. <b>15</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>ST. MARY'S COUNTY, MD.</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE COUNTY,</b> Md.  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VET. ADM. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>STATE ROADS</b>   |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>ANNE ARUNDEL</b>  |  |  | 13c. CITY OR TOWN<br><b>ANNAPOLIS</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>ROUTE 1, Box 622</b>                |  |  |  |  |  |
| 14. FATHER'S NAME<br>First <b>DENT</b> Middle <b>HEARD</b> Last <b>HEARD</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>ANNA</b> Middle <b>CLARK</b> Last <b>CLARK</b>                       |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>YES</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>214 05 28 38</b>   |  |  | 17. INFORMANT<br>Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  |  |   |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC DECOMPENSATION</b><br><b>4299</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4347</b><br>(b) <b>PULMONARY HYPERTENSION</b><br>(c) <b>PULMONARY EMPHYSEMA</b>              |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>GENERALIZED ARTERIOSCLEROSIS</b>   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>              |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |   |  |  |  |  |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>1/27/68</b> , 19 <b>68</b> , to <b>2/26/68</b> , 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>2/26/68</b> , 19 <b>68</b> , and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>John D. Talbert, M.D.</b>  |  |  |   |  |  |   |  |  |   |  |  | 22c. DATE SIGNED<br><b>2/26/68</b>                               |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>   |  |  | 22e. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |  |   |  |  |   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>2-29-68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HILLCREST CEMETERY</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ANNAPOLIS, MD.</b>                          |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John M. Taylor</b>   |  |  | ADDRESS<br><b>TAYLOR FUNERAL HOME</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 28 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |  |  |  |  |

02150

02200

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |                        |  |
|---|--|--|--|---|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |                        |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |   | 2a. DATE OF DEATH  |   |  | 2b. HOUR                                 |                        |  |
| First Middle Last<br>William P. Heatterich  |  |  |  |   | Month Day Year<br>Feb. 9, 1968   |   |  | 12.30 P.M.                               |                        |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |                        |  |
| Male  |  | White  |  | Feb. 14, 1892   |  | 75 YRS.   |  |  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                        |  |
| Md.   |  | U. S. A.   |  |   |  | Baltimore Md.   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY        |                        |  |
| Towson  |  |  | Chesapeake Manor Nursing Home  |   |  | American Ice Co.  |  | Platform                                 |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Md.   |  |  | Baltimore  |   | Rockdale   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 3808 Cordoned Rd.      |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last   |   |  |  |                        |  |
| Conrad Heatterich   |  |  |  |   | Rosie Pfarr  |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address  |   |  |  |                        |  |
| no  |  |  | 214-01-5203  |   | Mrs. Caroline L. Heatterich 3808 Cordoned Rd.  |   |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Thrombosis<br>4339 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>MONTHS |  |  |  |   |  |   |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>3322X   |  |  |  |   |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 12, 1967, to Feb 9, 1968, that (I) (we) last saw the deceased alive on Feb 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |                        |  |
| 22b. SIGNATURE<br>Luis J. Elias, M.D.   |  |  |  |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   |  | 22c. DATE SIGNED<br>2/10/68              |                        |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Luis J. Elias, M.D.   |  |  |  |   | 22e. ADDRESS<br>1701 Meridene Dr. Baltimore, Md. 21212   |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                        |  |
| Burial  |  | 2-12-1968  |  | Woodlawn  |  | Woodlawn, Balto. Md.  |  |  |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE  |   | 25b. REGISTRAR'S SIGNATURE   |  |                        |  |
| G. Howard Strong 3207 W. North Ave.,  |  |  |  |   | FEB 13 1968  |   | Charles Judge  |  |                        |  |



03180

03180

SI IS . . .



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |                                    |   |   |   |                          |                                |     |
|---|--|--|--|------------------------------------|---|---|---|--------------------------|--------------------------------|-----|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |                                    |   |   |   |                          |                                |     |
| CERTIFICATE OF DEATH  |  |  |  |                                    |   |   |   |                          |                                |     |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  |                                    | Middle  |   | Last  |                          | 2a. DATE OF DEATH              |     |
| Carl  |  |  | E.   |                                    | Hensley   |   | February  |                          | Month                          | Day |
| 3. SEX  |  |  | 4. RACE  |                                    | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |                          | 2b. HOUR                       |     |
| Male  |  |  | White  |                                    | 10-27-1897  |   | 70  |                          | 5.40PM                         |     |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |                          | IF UNDER 1 YEAR<br>MONTHS DAYS |     |
| Virginia  |  |  | U.S.A.   |                                    |   |   | Baltimore   |                          | IF UNDER 24 HRS.<br>HOURS MIN. |     |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |                          |                                |     |
| Towson  |  |  | St. Joseph Hospital  |                                    | FARM LABOR  |   | FARMING   |                          |                                |     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. CITY  |                                    | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                          | 13e. STREET AND NUMBER         |     |
| Md.   |  |  | BALTIMORE  |                                    | Phoenix   |   | YES   |                          | Jarrettsville Pike             |     |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |                                    |   |   |   |                          |                                |     |
| First Middle Last   |  |  | First Middle Last  |                                    |   |   |   |                          |                                |     |
| ELLSWORTH THOMAS HENSLEY  |  |  | MARY EMMA BREEDEN  |                                    |   |   |   |                          |                                |     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |                                    |   | 17. INFORMANT Address                         |   |                          |                                |     |
| No  |  |  | 220/09/7636  |                                    |   | MRS. MARY M. HENSLEY, PHOENIX, MD.            |   |                          |                                |     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |                                    |   |   |   |                          |                                |     |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |                                    |   |   |   |                          |                                |     |
| IMMEDIATE CAUSE (a) Uremia  |  |  |  |                                    |   |   |   |                          |                                |     |
| 593.2 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |                                    |   |   |   |                          |                                |     |
| Chronic renal disease, C.H.F.   |  |  |  |                                    |   |   |   |                          |                                |     |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |                                    |   |   |   |                          |                                |     |
| (c)   |  |  |  |                                    |   |   |   |                          |                                |     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |                                    |   |   |   |                          |                                |     |
| 593.2   |  |  |  |                                    |   |   |   |                          |                                |     |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                          |                                |     |
|   |  |  |  |                                    |   |   |   |                          |                                |     |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |   |                          |                                |     |
|   |  |  |  |                                    |   |   |   |                          |                                |     |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |                          | County State                   |     |
|   |  |  |  |                                    |   |   |   |                          |                                |     |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/11, 1968, to 2/17, 1968, that (I) (we) lost the deceased on 2/17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |                                    |   |   |   |                          |                                |     |
| 22b. SIGNATURE Alexis S. Sayoc M.D.   |  |  |  |                                    |   |   |   | 22c. DATE SIGNED 2-17-68 |                                |     |
| 22d. PHYSICIAN'S NAME (Type) Alexis Sayoc M.D.  |  |  |  |                                    | 22e. ADDRESS 7620 York Rd. Towson, Md. 21204  |   |   |                          |                                |     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State) |   |                          |                                |     |
| BURIAL  |  | 2/20/68  |  | MT. OLIVET PRES. CEME.             |   | RFD HANCOCK WASH., MD.                        |   |                          |                                |     |
| 24. FUNERAL DIRECTOR  |  |  |  |                                    | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |   |   |                          |                                |     |
| Howard F. Stone Hancock Md  |  |  |  |                                    | DATE FEB 23 1968  |   |   |                          |                                |     |

MEDICAL CERTIFICATION

1520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |   |   |  |                           |   |  |
|--|--|--|---|---|---|--|---------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |   |   |  |                           |   |  |
| CERTIFICATE OF DEATH   |  |  |   |   |   |  |                           |   |  |
| 1. DECEASED NAME<br>(Type or print) <b>DESSIE GERTRUDE HERRING</b>   |  |  |   |   | 2a. DATE OF DEATH<br>Month <b>Feb</b> Day <b>7</b> Year <b>1968</b> |  | 2b. HOUR<br><b>8:30 P</b> |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>Aug 31, 1887</b>   |   | 6. AGE (In years last birthday)<br><b>80</b> YRS.  |                           | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN        |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>   |                           | Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Freeland</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Middletown Rd</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House wife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |                           |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Freeland</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           | 13e. STREET AND NUMBER<br><b>Middletown Rd.</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>George Kyger</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Louise BAUGHER</b> |   |   |  |                           |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>225-01-4313</b>                      |   | 17. INFORMANT Address<br><b>Mrs Floyd LAM. Freeland Md</b>          |  |                           |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br><b>4129</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerotic Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |   |   |  |                           |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4251</b>  |  |  |   |   |   |  |                           |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                           |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |                           |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                         |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |                           |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JAN. 2, 1952</b> to <b>Feb 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |  |                           |   |  |
| 22b. SIGNATURE<br><b>Joseph E. Bush</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |   |   | 22c. DATE SIGNED<br><b>FEB 7 1968</b>  |                           |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Joseph E. Bush MD</b>   |  |  |   |   |   | 22e. ADDRESS<br><b>HAMPSTEAD Maryland</b>  |                           |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-10-1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gunpowder Baptist</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Freeland, Baltimore, Md.</b>             |                           |   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Towson, Md.</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br><b>FEB 13 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                           |   |  |

MEDICAL CERTIFICATION

00330

RECORDS OF DEATH

00330

1. Name of deceased  
2. Date of death  
3. Place of death  
4. Cause of death  
5. Age at death  
6. Sex  
7. Race  
8. Religion  
9. Marital status  
10. Occupation  
11. Education  
12. Social status  
13. Family history  
14. Medical history  
15. Mental history  
16. Physical examination  
17. Laboratory tests  
18. Post-mortem examination  
19. Burial place  
20. Burial date  
21. Burial time  
22. Burial method  
23. Burial cost  
24. Burial insurance  
25. Burial society  
26. Burial fund  
27. Burial fund balance  
28. Burial fund interest  
29. Burial fund dividends  
30. Burial fund total

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |                            |  |
|--|--|--|--|--|--|---|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |                            |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |                            |  |
| 02213  |  |  |  |  |  |   |  |                            |  |
| 02201  |  |  |  |  |  |   |  |                            |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  |                            | 2b. HOUR                                     |
| Gertrude   |  |  | M.   |  |  | Hettinger   |  |                            | Month 2 Day 5 Year 68 1:30 PM                |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday)  |                            | IF UNDER 1 YEAR                              |
| Female   |  | White  |  | 2-16-84  |  |   | 83 YRS.  |                            | MONTHS DAYS HOURS MIN.                       |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                            |  |
| Austria  |  | U.S.A.   |  |  |  | Baltimore, Md.  |  |                            |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                            | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Baltimore, Md.   |  |  | Foxgloves Convalescent   |  |  |   |  |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                            | 13e. STREET AND NUMBER                       |
| 418 E. 26th St.  |  |  | Baltimore  |  | Maryland   |   |  |                            | Valley & Lexington Rd.                       |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |                            |  |
| First Middle Last  |  |  | First Middle Last  |  |  |   |  |                            |  |
| Tasch, George  |  |  | Frombach, Margaret   |  |  |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   |  |                            | Address                                      |
|  |  |  | 30-000841-840  |  | John C. Hettinger - 418 E. 26th St                                     |   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction  |  |  |  |  |  |   |  |                            | minutes                                      |
| 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerosis   |  |  |  |  |  |   |  |                            | unknown                                      |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |                            |  |
| 4201   |  |  |  |  |  |   |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                            |  |
|  |  |  |  |  |  |   |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                            |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |   |  |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION  |  | Street or R.F.D. No.  |  | City or Town County State  |  |
|  |  |  |  |  |  |   |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-20, 1968, to Feb 5, 1968, that (I) (we) last saw the deceased alive on 2-4-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                            |  |
| 22b. SIGNATURE   |  |  |  |  |  | 22c. DATE SIGNED  |  |                            |  |
| David I. Miller M.D.   |  |  |  |  |  | 2-5-68  |  |                            |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  | 22e. ADDRESS  |  |                            |  |
| David I. Miller M.D.   |  |  |  |  |  | Lisbon Rd. Owings Mills Md  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)  |  | (County) (State)           |  |
| Burial   |  | 2-8-68   |  | Moreland Memorial  |  | BALTO, Md   |  |                            |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE |  |
| Ellsworth Armbrast - 4600 Liberty Hgts Ave   |  |  |  |  |  | DATE FEB 6 1968   |  | Charles Judge              |  |

10330

10330

RECEIVED

10330

10330

10330

10330

10330



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |                                   |  |  |
|---|--|--|--|--|--|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |                                   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR                          |  |  |
| ELLA G. HICKCOX   |  |  |  |  |  | Month February Day 17 Year 1968   |  | M                                 |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |  |  |
| Female  |  | White  |  | January 7, 1875  |  | 93 YRS.   |  | MONTHS DAYS HOURS MIN.            |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Ohio  |  | U.S.A.   |  |  |  | Baltimore   |  | Md.                               |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |                                   |  |  |
| Towson  |  |  | Chesapeake Manor   |  |  | Homemaker   |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Maryland  |  |  |  |  | Baltimore  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |                                   | 1514 Waverly Way                             |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |   |  |                                   |  |  |
| George W. Gichhorn  |  |  | Rachel Doubrava  |  |  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   | Address  |                                   |  |  |
| No  |  |  | 213-10-6508 D  |  | Mrs. Estelle M. Thomas   |   | Same   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.9 Cerebral Thrombosis  |  |  |  |  |  |   |  |                                   | MONTHS                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA  |  |  |  |  |  |   |  |                                   | DAYS   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |                                   |  |  |
| 332X  |  |  |  |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1st 1965, to Feb 16, 1968, that (I) (we) last saw the deceased alive on Feb 16 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE  |  | Dr. Luis J. Elias  |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED FEB. 19/68       |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | Dr. Luis J. Elias  |  | 22e. ADDRESS   |  | 1701 Meredene Drive Baltimore, Md.  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| Burial  |  | 2-20-68  |  | Lorraine   |  | Baltimore, Maryland   |  |                                   |  |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                                   |  |  |
| Mitchell-Wiedefeld Home, Inc.   |  | 6500 York Rd. Baltimore, Md. 21212   |  | DATE FEB 21 1968   |  | F. Clark Judge  |  |                                   |  |  |

MEDICAL CERTIFICATION

08280

RECEIVED

08280

February 17, 1930

ALL INFORMATION

|                   |         |                  |
|-------------------|---------|------------------|
| George J. Johnson | White   | February 7, 1929 |
| Johnson           | W.S.A.  | Baltimore        |
| Johnson           | Johnson | Baltimore        |
| Johnson           | Johnson | Baltimore        |
| Johnson           | Johnson | Baltimore        |
| Johnson           | Johnson | Baltimore        |
| Johnson           | Johnson | Baltimore        |
| Johnson           | Johnson | Baltimore        |
| Johnson           | Johnson | Baltimore        |
| Johnson           | Johnson | Baltimore        |

1001 Western Drive, Baltimore, Md.

February 17, 1930

George J. Johnson

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02215

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02203

|  |  |  |  |  |                                 |   |  |  |  |  |  |
|--|--|--|--|--|---------------------------------|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |  | First Middle Last  |  |                                 | 20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year<br>OF ESTI-<br>DEATH MATED <input type="checkbox"/> FEB. 17 1968  |  |  | 2b. HOUR<br>M  |  |  |
| 3. SEX<br>M  |  |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>AUG 16 1891 |   | 6. AGE (In years<br>lost birthday) 76 YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) FLORIDA   |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |                                 | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 9. COUNTY OF DEATH<br>BALTO Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>BALTO MD  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) 94 POPLAR RD |  |                                 | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) GARDENER   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY BALTO CITY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE MD  |  |  | 13b. COUNTY BALTO  |  |                                 | 13c. CITY OR TOWN ESSEX   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>UNKNOWN   |  |  | 15. MOTHER'S MAIDEN NAME<br>UNKNOWN  |  |                                 | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) NO  |  |  | 16b. SOCIAL SECURITY NO. 218-10-4959   |  |  |
| 17. INFORMANT<br>HILMA M. HILL   |  |  | ADDRESS<br>94 POPLAR RD.   |  |                                 | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100 Acute Coronary Occlusion<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br>4201 ACUTE |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?   |  |                                 | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. 19 P.M.                                    |  |                                 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)              |  |                                 | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |                                 |   |  |  |  |  |  |
| ACTUAL<br>SIGNATURE Theo C. Patterson  |  |  | M.D.   |  |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  | 22b. DATE SIGNED 2/13/68   |  |  |
| EXAMINER'S<br>NAME (Type) THEO. C. PATTERSON   |  |  | ADDRESS (Street, city, town, or county)  |  |                                 | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |  | 23b. DATE 2/15/68  |  |                                 | 23c. NAME OF CEMETERY OR CREMATORY LONDON PARK CEM  |  |  | 23d. LOCATION (City or Town) (County) (State) BALTO MD                                       |  |  |
| 24. FUNERAL DIRECTOR   |  |  | ADDRESS  |  |                                 | 25a. REC'D BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| WEBER FUNERAL HOME   |  |  | 531 EDWARDS AVE  |  |                                 | DATE FEB 13 1968  |  |  | Charles Judge  |  |  |

60356

1989

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02216  |  |  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                  |  |  |  |                             |  |  |  |                            |  |  |  | 02204      |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|----------------------------|--|--|--|------------|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last   |  |  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year   |  |  |  |                             |  |  |  |                            |  |  |  | 2b. HOUR M |  |  |  |  |  |  |  |  |  |  |  |
| Mildred A. Hiltz   |  |  |  |  |  |  |  |  |  |  |  | February 3 1968  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  | 4. RACE  |  |  |  | 5. DATE OF BIRTH   |  |  |  | 6. AGE (In years last birthday)  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| Female   |  |  |  | White  |  |  |  | March 20, 1896   |  |  |  | 71 YRS.  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH   |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  | U.S.A.   |  |  |  |  |  |  |  | Baltimore  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| Woodstock  |  |  |  | Davis Avenue   |  |  |  | Housewife  |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER      |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  | Baltimore  |  |  |  | Woodstock  |  |  |  |  |  |  |  | Davis Ave                   |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| John Albert  |  |  |  | Anna T Mulhern   |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT Address  |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| No   |  |  |  |  |  |  |  | James E Hiltz  |  |  |  | Same   |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 Acute myocardial infarction  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks   |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/3 1968, to 2/3 1968; that (I) (we) lost sight of the deceased on 2/3 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE [Signature]   |  |  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 2/3/68  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) Dr. Morton Ellin  |  |  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS 8629 Liberty Rd. Randallstown, Md   |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  | 2/6/68   |  |  |  | New Cathedral  |  |  |  | Baltimore Maryland   |  |  |  |                             |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS   |  |  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE   |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |
| Leonard J. Ruck Inc. 5305 Harford Rd. Balto  |  |  |  |  |  |  |  |  |  |  |  | 5 1968   |  |  |  | Charles Judge               |  |  |  |                            |  |  |  |            |  |  |  |  |  |  |  |  |  |  |  |

48384

02314

Miss

Miss

February 2 1902

David L. Evans

Bookman

at Davis Ave

Northbrook

Northbrook

and

James

James

1902

James L. Evans

1902

Miss L. Evans, Northbrook, Ill.

Miss L. Evans, Northbrook, Ill.

Miss L. Evans

Miss L. Evans

Miss L. Evans

1902

Miss L. Evans, Northbrook, Ill.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> <span>02217</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02265</span> </div>   |  |  |   |   |  |   |   |  |   |   |                             |
|--|--|--|---|---|--|---|---|--|---|---|-----------------------------|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>LESLIE CORNELIUS HINES</b>  |  |  |   |   |  | 2a. DATE OF DEATH Month Day Year<br><b>2 23 68</b>  |   |  | 2b. HOUR<br><b>4:30</b><br>P. M.                    |   |                             |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>NEGRO</b>  |   | 5. DATE OF BIRTH<br><b>9 4 06</b>   |  |   | 6. AGE (In years last birthday)<br><b>61</b> YRS. |  | IF UNDER 1 YEAR MONTHS DAYS                         |   | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>WEST INDIES</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |   |  | Md.   |   |                             |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADM. HOSPITAL</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OIL CO.</b> |   |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. CITY<br><b>BALTIMORE</b>   |   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>332 SNOW HILL ROAD</b>             |                             |
| 14. FATHER'S NAME First Middle Last<br><b>JAMES HINES</b>  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>AMANDA DASKENS</b>   |   |  |   |   |  |   |   |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW-11</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>218 10 54 05</b>   |   |  | 17. INFORMANT Address<br><b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>                                     |   |  |   |   |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>431.9 IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>337X</b>  |  |  |   |   |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 MONTHS</b> |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>PNEUMONIA</b>   |  |  |   |   |  |   |   |  |   |   |                             |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |   |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |   |   |                             |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |  |   |   |                             |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 8</b> , 19 <b>67</b> , to <b>Feb. 23</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 23</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |   |  |   |   |                             |
| 22b. SIGNATURE<br><i>Ralph M. Howard, M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |   |   |  |   |   | 22c. DATE SIGNED<br><b>2 24 68</b>   |   |   |                             |
| 22d. PHYSICIAN'S NAME (Type)<br><b>RALPH M. HOWARD, M. D.</b>  |  |  |   | 22e. ADDRESS<br><b>VAH, FT. HOWARD, MARYLAND</b>  |  |   |   |  |   |   |                             |
| 23a. BURIAL, CREMATION, (Specify)<br><b>BURIAL</b>   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                               |   |  |   |   |                             |
| 24. FUNERAL DIRECTOR<br><b>Morton &amp; Dyett Funeral Home, Baltimore, Md.</b>   |  |  |   | 1701 ADDRESS<br><b>Laurens Ave.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>FEB 27 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |   |   |                             |

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |   |  |   |  |
|--|--|--|--|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |  |   |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |  |   | 2b. HOUR                                     |
| Carrie   |  |  | HOFFMAN  |   |   | Month Day Year<br>February 8, 1968  |  |   | 4:25 p. M                                    |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   |   | 6. AGE (In years last birthday)                                      |   | 7. IF UNDER 1 YEAR                           |
| Female   |  | White  |  | April 22, 1865  |   |   | 82 yrs.  |   | IF UNDER 24 HRS.                             |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH   |   |  |
| Maryland   |  | U.S.A.   |  |   |   |   | Baltimore Md.  |   |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Towson   |  |  | ST. JOSEPH HOSPITAL  |   |   | Homemaker   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  |  |  |   |   | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |   |  |   |  |
| 2712 Berwick Ave.  |  |  |  |   |   |   |  |   |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |   |  |
| First Middle Last<br>George Ehrhardt   |  |  | First Middle Last<br>Mary Carey  |   |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   |   | 17. INFORMANT Address   |  |   |  |
| No   |  |  | 220-48-5275  |   |   | Mr Philip Spies 5613 Laurelton Avenue 21214   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive recurrent myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>coronary thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                               |  |  |  |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
|  |  |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |  |   |  |
|  |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |   |   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |   | Street or R.F.D. No.  |  | City or Town  | County State                                 |
|  |  |  |  |   |   |   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>12/25/</u> , 19 <u>67</u> , to <u>2/8/</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2/8/</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |  |   |  |
| 22b. SIGNATURE   |  |  |  |   |   | DEGREE  |  | 22c. DATE SIGNED  |  |
| Reynaldo Orjuela-Gomez, M.D.   |  |  |  |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | February 9, 1968  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |   |   | 22e. ADDRESS  |  |   |  |
|  |  |  |  |   |   | 7620 York Rd., Towson, Md. 21204  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)  |  | (County)  | (State)                                      |
| Burial   |  | 2-12-1968  |  | Parkwood Cemetery   |   | Baltimore   |  | Co.   | Md.  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |   | ADDRESS   |  | 25a. REC'D BY REGISTRAR   |  |
| Lecsalon Funeral Home 2401 Belair Rd.  |  |  |  |   |   | 36  |  | DATE FEB 13 1968  |  |
|  |  |  |  |   |   |   |  | 25b. REGISTRAR'S SIGNATURE  |  |
|  |  |  |  |   |   |   |  |   |  |

KTSSD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
|--|--|--|--|--|--|---|---------------------------------|--|-----------------------------------|----------------------------|-----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |                                 |  | 2b. HOUR                          |                            |                             |
| Daniel Bernard Hoffman   |  |  |  |  |  | Feb. Month 21 Day 1968  |                                 |  | 1.p.m.                            |                            |                             |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years lost birthday) |  | IF UNDER 1 YEAR MONTHS DAYS       |                            | IF UNDER 24 HRS. HOURS MIN. |
| Male   |  | White  |  | June 3, 1892   |  |   | 75 YRS.                         |  |                                   |                            |                             |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |                                 |  |                                   |                            |                             |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore Md.   |                                 |  |                                   |                            |                             |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |                            |                             |
| Towson   |  |  | Greater Baltimore Med. Cent.   |  |  | Farmer  |                                 |  |                                   |                            |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER     |                             |
| Maryland   |  |  | Washington   |  |  | Smithsburg  |                                 |  |                                   |                            |                             |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |                                 |  |                                   |                            |                             |
| First Middle Last  |  |  | First Middle Last  |  |  |   |                                 |  |                                   |                            |                             |
| John W. Hoffman  |  |  | Emma Rowe  |  |  |   |                                 |  |                                   |                            |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |                                 |  | Address                           |                            |                             |
| no   |  |  | 220-30-9596A   |  |  | Mr. Roger E. Rowe   |                                 |  | Smithsburg #3, Md.                |                            |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| IMMEDIATE CAUSE (a) Widespread metastatic CA of mouth  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| 1459 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| (b)  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| (c)  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| 144X   |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |                            |                             |
|  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |                                 |  |                                   |                            |                             |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |   |                                 |  |                                   |                            |                             |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.  |                                 | City or Town   |                                   | County State               |                             |
|  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| 22a. I certify that (a) (this hospital) attended the deceased from Feb. 7, 1968, to Feb. 21, 1968, that (a) (we) lost saw the deceased alive on Feb. 20, 1968, and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| 22b. SIGNATURE   |  |  |  |  |  |   |                                 | 22c. DATE SIGNED   |                                   |                            |                             |
| M. Estell Connolly   |  |  |  |  |  |   |                                 | Feb. 21, 1968  |                                   |                            |                             |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |   |                                 | 22e. ADDRESS   |                                   |                            |                             |
|  |  |  |  |  |  |   |                                 |  |                                   |                            |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)  |                                 | (County)   |                                   | (State)                    |                             |
| Burial   |  | 2/24/1968  |  | Green Hill   |  | Waynesboro, Franklin, Penna.  |                                 |  |                                   |                            |                             |
| 24. FUNERAL DIRECTOR   |  |  |  | ADDRESS  |  |   |                                 | 25a. REC'D BY REGISTRAR  |                                   | 25b. REGISTRAR'S SIGNATURE |                             |
| Walter J. Horne  |  |  |  | Waynesboro, Penna  |  |   |                                 | DATE FEB 26 1968   |                                   |                            |                             |

02319

02301

Handel Bernard Hoffman Feb. 21 1938

Male White June 3, 1932 75

U.S.A. Baltimore

Green Baltimore N.C. Dent

Washington Baltimore X

John W. Hoffman June 1938

220-10-122 Mr. Robert E. Howe Baltimore 13, Md.

Witnessed investigation of mouth July 1938

X

Feb. 20 1938 Feb. 21 1938 X

Feb. 21, 1938

2/21/1938 Green Hill Baltimore, Penna. 2/21/1938



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |   |  |  |
|---|--|--|--|--|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH                                 |  | 2b. HOUR                                     |
| EMANUEL   |  |  |  | HOLLANDER  |  |  |  | FEBRUARY <sup>Month</sup> 23, 1968 <sup>Day</sup> |  | 1:30 PM                                      |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                                   |  | IF UNDER 24 HRS.                             |
| MALE  |  | WHITE  |  | FEBRUARY 24, 1889  |  | 78 YRS.  |  | MONTHS DAYS                                       |  | HOURS MIN                                    |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | Md.   |  |  |
| NEW YORK CITY   |  | U.S.A.   |  |  |  | BALTIMORE  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |  |
| PIKESVILLE  |  | MILFORD MANOR NURSING HOME   |  | EXECUTIVE RETIRED IMPORTER   |  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                            |  |  |
| MARYLAND  |  | BALTIMORE  |  | PIKESVILLE   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | MILFORD MILL RD.                                  |  |  |
| 14. FATHER'S NAME   |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME                          |  | First Middle Last                            |
| DAVID   |  |  |  | HOLLANDER  |  |  |  | ANNA  |  | ?  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  | #8  |  |  |
| NO  |  |  |  | MR. MORTON J. HOLLANDER  |  | 7941 LONG MEADOW ROAD  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |   |  |  |
| IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</u>  |  |  |  |  |  |  |  |   |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |   |  |  |
| (b) <u>CARDIAC ARREST.</u>  |  |  |  |  |  |  |  |   |  | SUDDEN.                                      |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |   |  |  |
| (c)   |  |  |  |  |  |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |   |  |  |
| 433.0 STOKES-ADAMS-SYNDROME   |  |  |  |  |  |  |  |   |  | 3 yr.  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 1968, to <u>2/23</u> , 1968, that (I) (we) last saw the deceased alive on <u>2/23</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED   |  |   |  |  |
| JOSEPH S. BLUM  |  | M.D.   |  |  |  | 2/23/68  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |  |  |  |  |   |  |  |
| JOSEPH S. BLUM  |  | 1115 N. CALVERT STREET   |  |  |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |  |
| BURIAL  |  | 2-26-68  |  | UNION FIELD  |  | LONG ISLAND, NEW YORK  |  |   |  |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  |  |  | DATE FEB 26 1968   |  | Charles Judge  |  |   |  |  |

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02221

Item #8, Film GL 50 7/21/72

CERTIFICATE OF DEATH

02269

|  |  |  |  |   |  |   |   |   |  |  |   |  |
|--|--|--|--|---|--|---|---|---|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br><b>JOHN</b>   |  | Middle<br><b>JAMES</b>  |  | Last<br><b>HOLLIFIELD</b>   |   | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>22</b> Year <b>1968</b> |  |  | 2b. HOUR A.M.<br><b>6:15</b> M.                 |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>August 8, 1900</b>   |  |   | 6. AGE (In years last birthday)<br><b>67</b> YRS. |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN <b>0</b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Fort Howard</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTE (If not in hospital give street address)<br><b>Veterans Administration</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Guard</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State Police</b>  |   |   |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Kingsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>Rt. 1 Box 683</b>                            |  |  |   |  |
| 14. FATHER'S NAME<br>First <b>James</b> Middle <b>Hollifield</b> Last <b>Hollifield</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Nellie</b> Middle <b>Bond</b> Last <b>Bond</b>   |  |   |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>Yes</b> (If yes give war or dates of service) <b>WW-1</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213 16 44 65</b>  |  | 17. INFORMANT<br>Address <b>Clinical Rcds VAH Fort Howard, Md.</b>  |  |   |   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>4200</b>   |  |  |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>CEREBRAL ARTERIOSCLEROSIS AND PULMONARY EMPHYSEMA.</b>  |  |  |  |   |  |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?      |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |   |  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Dec. 14, 1967</b> , to <b>Feb. 22, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 22, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>J. D. Talbert, M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |   |  |   |   | 22c. DATE SIGNED<br><b>2/23/68</b>  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>J. D. TALBERT, M.D.</b>   |  | 22e. ADDRESS<br><b>VA Hospital, Fort Howard, Md.</b>   |  |   |  |   |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REINTERMENT<br><b>Burial</b>   |  | 23b. DATE<br><b>Feb 26, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                     |   |   |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>George J. Jones</b>   |  | ADDRESS<br><b>4001 Gov Ritchie Hwy</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 27 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |   |  |  |   |  |

02291

02291

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
JANUARY 10, 1964  
MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]

On January 8, 1964, [Illegible] advised that [Illegible] had been contacted by [Illegible] who stated that [Illegible] was currently residing at [Illegible] address. [Illegible] further stated that [Illegible] was a [Illegible] and was currently working as a [Illegible] at [Illegible] location. [Illegible] also stated that [Illegible] was a [Illegible] and was currently working as a [Illegible] at [Illegible] location.

[Illegible text block containing several lines of text, mostly illegible due to poor scan quality.]

[Illegible text block containing several lines of text, mostly illegible due to poor scan quality.]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02222

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02210

|   |                         |  |  |   |  |  |  |   |  |   |  |
|---|-------------------------|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Evald</b>  |                         | First <b>F.</b>  |  | Middle <b>F.</b>  |  | Last <b>Holm</b>   |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month <b>Feb.</b> Day <b>15</b> Year <b>1968</b> |  | 2b. HOUR <b>9:00</b> AM   |  |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>Nov. 29, 1906</b>   |  | 6. AGE (In years last birthday)<br><b>61</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____   |  | IF UNDER 24 HRS<br>HOURS _____ MIN. _____   |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Feb.</b> Day <b>15</b> Year <b>1968</b>        |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Edgemere</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7841 North Cove Rd.</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Wire Mill - Bethlehem Steel Co.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                  |  | 13e. STREET AND NUMBER<br><b>7841 North Cove Road</b>   |  |   |  |
| 14. FATHER'S NAME<br><b>Frank</b>   |                         | First <b>Frank</b>   |  | Middle <b>Holm</b>  |  | Last <b>Holm</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Anna C. Anderson</b>   |  | First <b>Anna</b> Middle <b>C.</b> Last <b>Anderson</b>                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>214-26-8758</b>   |  | 17. INFORMANT (Wife)<br><b>Mrs. Ethel Holm, 7841 North Cove Rd.</b>   |  |  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASC-V- DISEASE</b><br>4129<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                         |  |  |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4221  |                         |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <b>19</b>                                     |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  | 21f. LOCATION Street or R.F.D. No. _____  |  | City or Town _____   |  | County _____  |  | State _____   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |  |   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis</b>  |                         | EXAMINER'S NAME (Type)<br><b>Melvin B. Davis</b>   |  | M.D.<br><b>M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>6800 Mornington Rd.</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>22b. DATE SIGNED</b>                         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dundalk, 2/15/68</b> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>2/19/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>FEB 19 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                    |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |                         | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 19 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |

01350

04530



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |  |  |   |   |                            |  |
|--|--|--|--|---|--|--|--|---|---|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |   |   |                            |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |   |                            |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>DAISY   |  | Middle<br>A.  |  | Last<br>HOOD   |  | 2a. DATE OF DEATH<br>Month 2 Day 9 Year 1968  |   |                            | 2b. HOUR<br>11:10 a.m.                       |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>August 30, 1873   |  |  | 6. AGE (In years last birthday)<br>94 YRS.                               |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.     |                            | IF UNDER 24 HRS.                             |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore  |  |   | Md.   |                            |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Center |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Lutherville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  | 13e. STREET AND NUMBER<br>Broadway Road   |   |                            |  |
| 14. FATHER'S NAME First Middle Last<br>Thomas Maxwell  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Annie Barlow  |  |  |  |   |   |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <input type="checkbox"/> None  |  | 16b. SOCIAL SECURITY NO.<br>None   |  | 17. INFORMANT<br>Family records   |  |  |  | Address   |   |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral thrombosis with extensive infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4129</u><br><u>4221</u> |  |  |  |   |  |  |  |   |   |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>Aspiration bronchopneumonia and pulmonary embolus</u>  |  |  |  |   |  |  |  |   |   |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |   |   |                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |   |                            |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town   |  | County  |   | State                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/29</u> , 19 <u>68</u> , to <u>2/9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |   |                            |  |
| 22b. SIGNATURE<br><u>John E. Adams</u>   |  |  |  |   |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>2/9/68 |  |
| 22d. PHYSICIAN'S NAME (Type)<br>John E. Adams, M. D.   |  |  |  | 22e. ADDRESS<br>Greater Baltimore Medical Center  |  |  |  |   |   |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>Feb. 12, 1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Prospect Hill Cemetery  |  | 23d. LOCATION (City or Town)<br>Towson, Maryland   |  | (County)  |   | (State)                    |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns Sons</u>   |  |  |  | ADDRESS<br><u>Lutwin</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 13 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. [unclear]</u>   |   |                            |  |

11380

83230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |  |  |                        |  |
|--|--|--|--|--|---|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |  |                        |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |  |                        |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  | 2b. HOUR   |                        |  |
| DORA   |  |  | E. HOPPER  |  |   | Feb. Month 9 Day 1968 Year  |  | 7:15 M   |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN. |                        |  |
| Female   |  | White  |  | 4-3-1873   |   | 94 YRS.   |  |  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  | Md.  |                        |  |
| N.Y.   |  | USA  |  |  |   | Baltimore   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |                        |  |
| Baltimore 21212  |  |  | Armacost N.H.  |  |   | Housewife   |  | Own Home   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Md.  |  |  |  |  | Balto.  |   |  |  | 4212 Kelway Rd.        |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |  |                        |  |
| First Middle Last  |  |  | First Middle Last  |  |   |   |  |  |                        |  |
| Otis C. Smith  |  |  | Maria Perlee   |  |   |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT Address   |  |  |                        |  |
| No   |  |  | 051-14-7053  |  |   | Mrs. Ruth Clegg Above   |  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC BRAIN SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS GENERALIZED 4221 YEARS. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 3 YEARS YEARS. |  |  |  |  |   |   |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) A.S.C.V. DISEASE  |  |  |  |  |   |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |  | County State   |                        |  |
|  |  |  |  |  |   |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1950, to FEB. 9, 1968, that (I) (we) last saw the deceased alive on FEB. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |  |  |  |   |   |  |  |                        |  |
| 22b. SIGNATURE Dr. Arthur Karfgin M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  |   |   |  | 22c. DATE SIGNED 2/10/68                               |                        |  |
| 22d. PHYSICIAN'S NAME (Type) Dr. Arthur Karfgin  |  |  |  | 22e. ADDRESS 1532 Havenwood Rd., Balto., Md.   |   |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |  |                        |  |
| Burial   |  | 2-13-68  |  | Beechwood  |   | New Rochelle N.Y.   |  |  |                        |  |
| 24. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd., Balto., Md.  |  |  |  | 25a. REC'D BY REGISTRAR DATE FEB 13 1968   |   | 25b. REGISTRAR'S SIGNATURE Charles Judge  |  |  |                        |  |

02319

02320

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR   |  |  |
| George   |  |  | Henry  |  |  | Houck  |  |  | Month Day Year   |  |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)  |  |  |
| Male   |  |  | White  |  |  | 7-17-91  |  |  | 76 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |  |
| Maryland   |  |  | U.S.A.   |  |  |  |  |  | Baltimore Md.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Randallstown   |  |  | Baltimore Co. Gen. Hosp.   |  |  | Police - P.R.R. - #7   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| Md.  |  |  | Baltimore  |  |  | BALTO  |  |  | 3637 Coronado Rd   |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |
| Milton   |  |  | Houck  |  |  | AGNES  |  |  | AMOS   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | Address  |  |  |
| No.  |  |  | 717-07-7824  |  |  | Amelia J. Houck - Same   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  |  |  |
| 1519 Metastatic Carcinoma  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |
| (b) Adenocarcinoma of stomach  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |
| (c)  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)                 |  |  |  |  |  |  |  |  |  |  |  |
| 1519   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) |  |  | 21b. TIME OF INJURY  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
|  |  |  | HOUR A.M. Month Day Year   |  |  |  |  |  |  |  |  |
|  |  |  | P.M. 19  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION  |  |  | Street or R.F.D. No. City or Town County State   |  |  |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost                             |  |  |  |  |  |  |  |  |  |  |  |
| saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the                           |  |  |  |  |  |  |  |  |  |  |  |
| causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |
| Charles V. Patricio M.D. DEGREE  |  |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  |  | 2/28/68  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Burial   |  |  | 3-1-68   |  |  | Lorraine Pk. Cemetery  |  |  | Baltimore Md.  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | 25a. REGD BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Elsworth Armacost - 4600 Liberty Bkts Ave  |  |  |  |  |  | DA FEB 29 1968   |  |  | J. Charles Judge   |  |  |

MEDICAL CERTIFICATION

4258

41596



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

|  |  |   |  |   |  |  |  |  |  |   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 02226 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  |   |  |
| 02214  |  |   |  |   |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>o. COUNTY <u>Baltimore</u> MARYLAND   |  |   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Riderwood</u>   |  |   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Riderwood</u>   |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>1715 W. Joppa Road</u>  |  |   |  |   |  | d. STREET ADDRESS<br><u>1715 W. Joppa Road</u>   |  |  |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Willard Alban Howard</u>   |  |   |  |   |  | 4. DATE OF DEATH<br>Month <u>February</u> Day <u>15</u> Year <u>1968</u>   |  |  |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>White</u>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>November 18, 1917</u>   |  | 9. AGE (In years lost birthday)<br><u>56</u> yrs.                      |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Electrician</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Self employed</u>   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>    |  |
| 13. FATHER'S NAME<br><u>James P. Howard</u>  |  |   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Bessie A. Alban</u>   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br><u>Family records</u>   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4109</u> <u>acute coronary occlusion</u><br>DUE TO (b) <u>Coronary artery disease</u><br>DUE TO (c) <u>39 years</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>minutes</u>   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>42201</u>  |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> , 19 <u>58</u> , to <u>Feb. 15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.  |  |   |  |   |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br><u>William F. Fritz</u>  |  |   |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  | 22b. DATE SIGNED<br><u>Feb. 16, 1968</u>                               |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM F. FRITZ, M.D.</u>   |  |   |  |   |  | 22d. ADDRESS<br><u>2 W. University Parkway, Balto 18, Md.</u>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>Feb. 17, 1968</u> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Jessops Methodist Cem.</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Cockeysville, Maryland</u>   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>  |  |   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>FEB 20 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. Jones</u>                  |  |   |  |

03330

03330

REMARKS ON CHART

THIS CHART IS THE PROPERTY OF THE UNITED STATES GOVERNMENT AND IS LOANED TO YOU BY THE NATIONAL ARCHIVES

03330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |  |  |   |   |  |                                |  |
|--|--|--|---|--|--|--|--|---|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |  |  |   |   |  |                                |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |  |  |   |   |  |                                |  |
| 02227  |  | 02215  |   |  |  |  |  |   |   |  |                                |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Theresa Huber  |  |  |   |  |  | 2a. DATE OF DEATH Month Day Year<br>Feb. 16 1968   |  |   | 2b. HOUR<br>7p.M                          |  |                                |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>Oct. 9, 1871   |  |  | 6. AGE (In years lost birthday)<br>96 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS            |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Germany   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                       |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Balto. County Md.  |  |   |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph's Hosp |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |  |   | 12b. KIND OF BUSINESS OR INDUSTRY         |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Perry Hall                      |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>4211 Chapel Rd. |  |                                |  |
| 14. FATHER'S NAME First Middle Last<br>- Zinser  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Unknown   |  |  |  |  |   |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. Teresa Clark - 4211 Chapel Rd. |  |  | Address   |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>486X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>493X</u><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____    |  |  |   |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Advanced arteriosclerosis</u>   |  |  |   |  |  |  |  |   |   |  |                                |  |
| 19a. DATE OF OPERATION<br>None   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |   |  |                                |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County  |   | State  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>62</u> , to <u>Feb. 16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb. 14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |   |   |  |                                |  |
| 22b. SIGNATURE<br><u>Theodore E. Evans</u> M.D. DEGREE   |  |  |   |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br>2-17-68                            |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Theodore E. Evans, M.D.  |  |  |   | 22e. ADDRESS<br>9660 Belair Road 21236   |  |  |  |   |   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>2/20/68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Joseph's Cem.  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Fullerton, Md.                              |   |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br>John C. Miller Inc.  |  |  |   | ADDRESS<br>6415 Belair Rd.   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 23 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |  |                                |  |

MEDICAL CERTIFICATION

03312

EXHIBIT OF CASE

03300

SEP 3 1935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |   |  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle  |  | Last   |  | 20. OATE OF OEAH<br>Month Day Year                                      |  | 2b. HOUR<br>10 <sup>30</sup> P M  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>10-9-95   |  | 6. AGE (In years<br>lost birthday)<br>72 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore  |  |   |  | Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>House in the Pine |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md  |  | 13b. COUNTY<br>BALTO   |  | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>625 Aldershot Rd                              |  |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br>EDWARD H. ROGERS  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>UNKNOWN   |  |   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>219-25-9764  |  | 17. INFORMANT<br>HELEN M. DUVALL 625 ALPERSHOT RD   |  | Address  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Vascular Disease</u><br><u>4120</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive Coronary Vascular Disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDIION GIVEN IN PART 1(a)<br><u>443X</u><br><u>Diabetic Mellitus, Recent Myocardial Infarction</u> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>1 mo.</u><br><u>10 yrs?</u> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDIION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>68</u> , to <u>Feb 23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb. 22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>J. Nelson McKay M.D.</u>   |  | 22c. DATE SIGNED<br><u>2-23-68</u>   |  | 22d. PHYSICIAN'S<br>NAME (Type)<br><u>J. NELSON MCKAY</u>   |  | 22e. ADDRESS<br><u>6014 EDMONDSON AVE</u>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>BURIAL</u>   |  | 23b. DATE<br><u>2-26-68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>DAVID RIDGE CEMETERY BALTO</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>MD.</u>                          |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>WEBER FUNERAL HOME 5314 EDMONDSON AVE</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>FEB 26 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |   |  |   |  |

05510

UNITED STATES OF AMERICA

05510



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH  |  |  |  |  |                                  |  |   |  |  |  |                             |
|---|--|--|--|--|----------------------------------|--|---|--|--|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) <u>Joseph</u> <u>Carl</u> <u>Thnat</u>   |  |  |  |  |                                  | 2a. DATE OF DEATH <u>Feb.</u> <u>17</u> <u>68</u>  |   |  | 2b. HOUR <u>1:30</u> <u>PM</u>                     |  |                             |
| 3. SEX <u>Male</u>  |  | 4. RACE <u>Can</u>   |  | 5. DATE OF BIRTH <u>3-6-1895</u>   |                                  |  | 6. AGE (In years last birthday) <u>72</u> YRS.                                    |  | IF UNDER 1 YEAR MONTHS DAYS                        |  | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <u>Penna</u>  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. COUNTY OF DEATH <u>Baltimore</u> Md.  |   |  |  |  |                             |
| 10. CITY OR TOWN OF DEATH <u>Towson</u>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Copeland Bldg. Med Ctr</u> |  |                                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>unknown</u>                                 |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>   |  |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Penna</u>  |  |  | 13b. COUNTY <u>PHILADELPHIA</u>  |  | 13c. CITY OR TOWN <u>PHOENIX</u> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <u>Sweet Air Rd. Box 44</u> |  |                             |
| 14. FATHER'S NAME First <u>Michael</u> Middle <u>Thnat</u> Last <u>Thnat</u>  |  |  |  | 15. MOTHER'S MAIDEN NAME First <u>unknown</u> Middle <u>unknown</u> Last <u>unknown</u>  |                                  |  |   |  |  |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>unknown</u> (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO. <u>unknown</u>  |                                  | 17. INFORMANT <u>Patients</u> Address <u>chart.</u>  |   |  |  |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Respiratory arrest.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Possible sudden myo cardiac infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Lung tumor and congestive failure</u>                     |  |  |  |  |                                  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>231X</u>  |  |  |  |  |                                  |  |   |  |  |  |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |                                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                  |  |   |  |  |  |                             |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                  |  |   |  |  |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-5-68</u> , 19 <u>68</u> , to <u>2-17-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-17-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                  |  |   |  |  |  |                             |
| 22b. SIGNATURE <u>Rahm Bassile</u>  |  |  |  |  |                                  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED <u>2-17-68</u>                                      |  |  |                             |
| 22d. PHYSICIAN'S NAME (Type) <u>Rahm m. Bassile</u>   |  |  |  |  |                                  | 22e. ADDRESS   |   |  |  |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE <u>2-21-68</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>  |                                  | 23d. LOCATION (City or Town) (County) (State) <u>HANOVER Township PA.</u>  |   |  |  |  |                             |
| 24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Inc.</u>  |  |  |  |  |                                  | 25a. REC'D BY REGISTRAR <u>1217 St Paul St Balto, Md. 21202</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>                      |  | DATE <u>FEB 20 1968</u>                      |                             |

03330

03330

03330

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |   |   |  |   |   |                                |
|---|--|------------------------------|--|---|---|--|---|---|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |   |   |  |   |   |                                |
| CERTIFICATE OF DEATH  |  |                              |  |   |   |  |   |   |                                |
| 1. DECEASED-NAME<br>(Type or print)   |  |                              | First Middle Last  |   |   | 2a. DATE OF DEATH  |   |   | 2b. HOUR                       |
| Eva W. Johnson  |  |                              |  |   |   | Month Day Year<br>2 8 68   |   |   | M                              |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH  |   |  | 6. AGE (In years<br>lost birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS |
| Female  |  | Cau                          |  | 11/18/87  |   |  | 80 YRS.   |   | IF UNDER 24 HRS.<br>HOURS MIN  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |   |                                |
| District Columbia   |  | USA                          |  |   |   | Baltimore Md.  |   |   |                                |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)  |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |                                |
| Catonsville   |  |                              | Summit Nursing Home  |   |   | Housewife  |   | Own Home  |                                |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE  |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                           |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER         |
| Md  |  |                              | Baltimore  |   | Catonsville                                 |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |   | 128 Cherrydell Rd              |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |   |   |  |   |   |                                |
| First Middle Last   |  |                              | First Middle Last  |   |   |  |   |   |                                |
| Unknown Harris  |  |                              | Ellen Webb   |   |   |  |   |   |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address                       |  |   |   |                                |
| No  |  |                              |  |   | Charles G. Johnson Same as 13e              |  |   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <u>chronic myocarditis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>arteriosclerotic cardiovascular disease</u><br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 da.<br>5 yr.<br>10 yrs. |  |                              |  |   |   |  |   |   |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201  |  |                              |  |   |   |  |   |   |                                |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)            |   |   |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)  |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                               |   |   |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-18</u> , 19 <u>62</u> , to <u>2-8-68</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>2-5-</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |                              | 22b. SIGNATURE<br><u>Wilmer K. Gallagher</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/><br>22d. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> |   |   | 22c. DATE SIGNED<br><u>2-9-68</u>  |   |   |                                |
| 22e. ADDRESS<br><u>6209 Frederick Ave., Balt. 21228 Md.</u>   |  |                              |  |   |   |  |   |   |                                |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY          |  | 23d. LOCATION (City or Town) (County) (State)   |   |                                |
| Burial  |  |                              | 2/12/68  |   | Woodlawn                                    |  | Woodlawn Balt Md  |   |                                |
| 24. FUNERAL DIRECTOR 6212 Balt Nat Pike<br>Wm. Cook-Brooks West Inc Balt. Md. 21228   |  |                              |  |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 13 1968 |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |                                |

03330

03330

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |   |                      |  |  |  |
|---|--|---|--|---|--|---|--|---|----------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |   |                      |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |                      |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>Lawrence, Haze, Johnson</b>   |  |   |  |   |  | 20. DATE OF DEATH<br>7 Month 9 Day 68 Year  |  |   | 2b. HOUR<br>12:50 PM |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br><b>7/29/18</b>  |  | 6. AGE (In years last birthday)<br><b>49</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                          |                      | IF UNDER 24 HRS.<br>HOURS MIN                |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>LaFollette, TENN</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |   | Md.                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GBMC</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |                      |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>BALTO</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  | 13e. STREET AND NUMBER<br><b>#27 2805 LOUISIANA AVE</b> |                      |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Joseph Johnson</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Elizabeth Johnson</b>  |  |   |  |   |                      |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>410-16-9050</b>  |  | 17. INFORMANT<br><b>Pt's chart</b>  |  |   |  | Address   |                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Brucellosis as a sequel of</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>1621   |  |   |  |   |  |   |  |   |                      | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>1621  |  |   |  |   |  |   |  |   |                      |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |                      |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                                  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |                      |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |                      |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1, 1968</b> , to <b>Feb. 9, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb. 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |                      |  |  |  |
| 22b. SIGNATURE<br><b>Quasstein Femi</b>   |  |   |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Feb. 9, 1968</b>                 |                      |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ANGUSTACIA FABIE</b>   |  |   |  | 22e. ADDRESS<br><b>GBMC</b>   |  |   |  |   |                      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>Feb. 12, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Randallstown, Md.</b>   |  |   |                      |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b>   |  |   |  | ADDRESS<br><b>3512 Frederick Ave, Balto. Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 13 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>      |                      |  |  |  |

01830

01830



U. S. National Archives and Records Administration  
Washington, D. C. 20540  
Box 12, 1000  
Lakewood, Colorado  
80120



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |                   |   |  |   |                                   |  |  |
|--|--|--|--|--|-------------------|---|--|---|-----------------------------------|--|--|
| 02232  |  |  |  |  |                   | 02220   |  |   |                                   |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last   |  |  |  |  |                   | 2a. DATE OF DEATH   |  |   |                                   | 2b. HOUR                                     |  |
| LLOYD M. JONES   |  |  |  |  |                   | 2 Month 24 Day 68 Year  |  |   |                                   | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |                   | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS   |                                   | IF UNDER 24 HRS. HOURS MIN.                  |  |
| m  |  | w  |  | 9/11/19  |                   | 48 YRS.   |  |   |                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. COUNTY OF DEATH  |  |   |                                   |  |  |
| MAINE  |  | U.S.A.   |  |  |                   | BALTIMORE Md.   |  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| CATONSVILLE  |  |  | 205 ROLLINGBROOK WAY   |  |                   | MARINE SURV.  |  |   | SHIP                              |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER            |  |  |
| Md   |  |  | BALTO  |  | CATONSVILLE       |   |  |   | 205 ROLLINGBROOK WAY              |  |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |                   |   |  |   |                                   |  |  |
| ONSLOW JONES   |  |  |  | ELIZABETH TAYLOR   |                   |   |  |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT     |   |  | Address   |                                   |  |  |
|  |  |  | 017-14-5773  |  | LENA M. JONES     |   |  |   |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4120 Acute Cardiac Arrhythmia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Coronary Artery Disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Atherosclerosis & Hypertension            |  |  |  |  |                   |   |  |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4201   |  |  |  |  |                   |   |  |   |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |                   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                   |   |  |   |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |                   | City or Town  |  | County  |                                   | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from June, 1965, to 24 Feb, 1968, that (I) (we) last saw the deceased alive on 24 Feb 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                   |   |  |   |                                   |  |  |
| 22b. SIGNATURE William J. Bryson M.D.  |  |  |  |  |                   | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED 26 Feb 68                   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |                   | 22e. ADDRESS  |  |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                   | 23d. LOCATION (City or Town) (County) (State)   |  |   |                                   |  |  |
| BURIAL   |  | 2/27/68  |  | LORRAINE   |                   | BALTO. CO. MD   |  |   |                                   |  |  |
| 24. FUNERAL DIRECTOR E.S. MACNABB  |  |  |  |  |                   | ADDRESS 301 FREDERICK RL 21228  |  | 25a. REC'D BY REGISTRAR DATE FEB 27 1968  |                                   | 25b. REGISTRAR'S SIGNATURE Charles Judge     |  |

03330

CONTINUED ON REVERSE

03330

1. 1000

1000 1000 1000

1000

1000

1000

1000

1000 1000

1000

1000

1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000

1000 1000 1000

1000 1000

1000 1000 1000 1000

1000

1000 1000 1000 1000

1000 1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
|--|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| 02233  |  | 02221  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  | First Middle Last  |  |  |  | 2a. DATE OF DEATH  |  |                                   |  | 2b. HOUR                                     |  |                            |  |
| WILLIAM JOSEPH KADE  |  |  |  |  |  |  |  | Month Day Year<br>February 25, 1968                                  |  |                                   |  | 12:05 PM                                     |  |                            |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |  |  | 6. AGE (In years lost birthday)                                      |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.                             |  |                            |  |
| male   |  | white  |  | Sept. 21, 1887   |  |  |  | 86 YRS.  |  | MONTHS DAYS                       |  | HOURS MIN.                                   |  |                            |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |                                   |  |  |  |                            |  |
| Germany  |  | USA  |  |  |  | Baltimore Md.  |  |  |  |                                   |  |  |  |                            |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |                            |  |
| Towson   |  | St. Joseph Hospital  |  |  |  | retired - Trucker  |  |  |  | Moving Co.                        |  |  |  |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |                                   |  |  |  |                            |  |
| Maryland   |  | Baltimore  |  | Towson   |  |  |  | Virginia Avenue  |  |                                   |  |  |  |                            |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                                   |  |  |  |                            |  |
| First Middle Last<br>Unknown   |  |  |  | First Middle Last<br>Unknown   |  |  |  |  |  |                                   |  |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |  |  | Address  |  |                                   |  |  |  |                            |  |
| No   |  | None   |  | 217-18-0115  |  | Family records   |  |  |  |                                   |  |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                            |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| IMMEDIATE CAUSE (a) Pulmonary Edema  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| (b) Congestive Heart Failure   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| (c) Arteriosclerotic Cardiovascular Disease  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| 4221   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |  |  |                            |  |
|  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |                                   |  |  |  |                            |  |
|  |  | HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town   |  | County                            |  | State  |  |                            |  |
|  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from February 17, 1968, to February 25, 1968, that (I) (we) last saw the deceased alive on Feb. 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |                                   |  |  |  |                            |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  |                                   |  | 22c. DATE SIGNED                             |  |                            |  |
| Antonio G. de Leon M.D.  |  |  |  |  |  |  |  |  |  |                                   |  | 2-25-68                                      |  |                            |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  |                                   |  | 22e. ADDRESS                                 |  |                            |  |
| Antonio G. de Leon, M.D.   |  |  |  |  |  |  |  |  |  |                                   |  | 7620 York Rd., Towson, Md. 21204             |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)   |  | (County)   |  | (State)                           |  |  |  |                            |  |
| Burial   |  | Feb. 28, 1968  |  | Loudon Park Cemetery   |  | Baltimore, Maryland  |  |  |  |                                   |  |  |  |                            |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  |                                   |  | 25a. REC'D BY REGISTRAR                      |  | 25b. REGISTRAR'S SIGNATURE |  |
| John Burns, Towson, Maryland   |  |  |  |  |  |  |  |  |  |                                   |  | DATE FEB 29 1968                             |  | John Burns                 |  |

MEDICAL CERTIFICATION

4320

1250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02234  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02222

|  |                              |  |   |   |                                     |   |                                |  |
|--|------------------------------|--|---|---|-------------------------------------|---|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |                              | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year |   | 2b. HOUR<br>PM                 |  |
| WILLIAM  |                              | FREDERICK  | KAMPES  | February 1, 1968  |                                     | 11:30   |                                |  |
| 3. SEX   | 4. RACE                      |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)     |   | IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| male   | white                        |  | January 20, 1909  |   | 59 YRS.                             |   |                                |  |
| 7a. BIRTHPLACE (State or foreign country)  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH                  |   | Md.                            |  |
| Maryland   | USA                          |  |   |   | Baltimore                           |   |                                |  |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                     | 12b. KIND OF BUSINESS OR INDUSTRY   |                                |  |
| Towson   |                              | St. Joseph Hospital  |   | Balto. Civic Center   |                                     | Maint.  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                |  |
| Maryland   |                              |  |   | Baltimore   |                                     | 13e. STREET AND NUMBER<br>1536 Abbottston St.   |                                |  |
| 14. FATHER'S NAME First Middle Last  |                              |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last  |                                     |   |                                |  |
| Christian Kampes   |                              |  |   | Katherine Krietler  |                                     |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |                                     |   |                                |  |
| No   |                              |  |   | Mrs. Catherine A. Kampes-- Same   |                                     |   |                                |  |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho-pneumonia of left lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Bronchogenic carcinoma of right lung.</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.             |                              |  |   |   |                                     |   |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>1621</u>  |                              |  |   |   |                                     |   |                                |  |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> DIRECT CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)         |                                     |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                     |   |                                |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>February 1, 1968</u> , to <u>February 19, 68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>February 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |  |   |   |                                     |   |                                |  |
| 22b. SIGNATURE <u>Sam J. Misanik</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |                              |  |   | 22c. DATE SIGNED<br><u>February 2, 1968</u>   |                                     |   |                                |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Lawrence F. Misanik, M.D.</u>  |                              |  |   | 22e. ADDRESS<br><u>7620 York Rd., Towson, Md. 21204</u>                                 |                                     |   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town) (County) (State)   |                                |  |
| Burial   |                              | 2/5/68   |   | Parkwood Cemetery   |                                     | Baltimore Co., Maryland   |                                |  |
| 24. FUNERAL DIRECTOR ADDRESS   |                              |  |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 2 1968  |                                     | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. J...</u>  |                                |  |
| Leonard J. Ruck Inc. 5305 Harford Rd.  |                              |  |   |   |                                     |   |                                |  |

03333

03333





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

|   |  |   |   |
|---|--|---|---|
| 02235   |  | 02223   |   |
| 1. DECEASED-NAME (Type or print)<br><b>Alfred</b>   |  | First Middle Last<br><b>K A R E</b>   |   |
| 2a. DATE OF DEATH<br>Month Day Year<br><b>February 15, 1968</b>   |  | 2b. HOUR<br><b>7:50 AM</b>  |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>December 20, 1888</b>  |   |
| 6. AGE (In years last birthday)<br><b>79 YRS.</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Estonia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Estonia</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. COUNTY OF DEATH<br><b>Baltimore,</b>   |  | Md.   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Caretaker</b> |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Hospital</b>  |  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Balto.</b>   | 13c. CITY OR TOWN<br><b>Balto.</b>  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |
| 13e. STREET AND NUMBER<br><b>7620 York Rd.,</b>   |  |   |   |
| 14. FATHER'S NAME First Middle Last<br><b>Jaan Kare</b>   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Tiiu Tint</b>  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>213-30-2117</b>  |   |
| 17. INFORMANT<br><b>Mrs. Anna M. Kare</b>   |  | Address<br><b>(Sa me)</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute massive hemorrhage</b><br><b>441.2</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Rupture of abdominal aortic aneurysm.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>451X</b> |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br><b>19</b>   |   |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   |
| 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/13/</b> , 19 <b>68</b> , to <b>2/15/</b> , 19 <b>68</b> , that <b>no</b> (we) last saw the deceased alive on <b>2/15/</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |   |
| 22b. SIGNATURE<br><b>Reynaldo Orjuela-Gomez, M.D.</b>   |  | 22c. DATE SIGNED<br><b>February 15, 1968</b>  |   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Reynaldo Orjuela-Gomez, M.D.</b>   |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/19/68.</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  | 25a. REC'D BY REGISTRAR<br><b>FEB 16 1968</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |   |

13288

RECEIVED

13288

FEB 18 1968

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02236

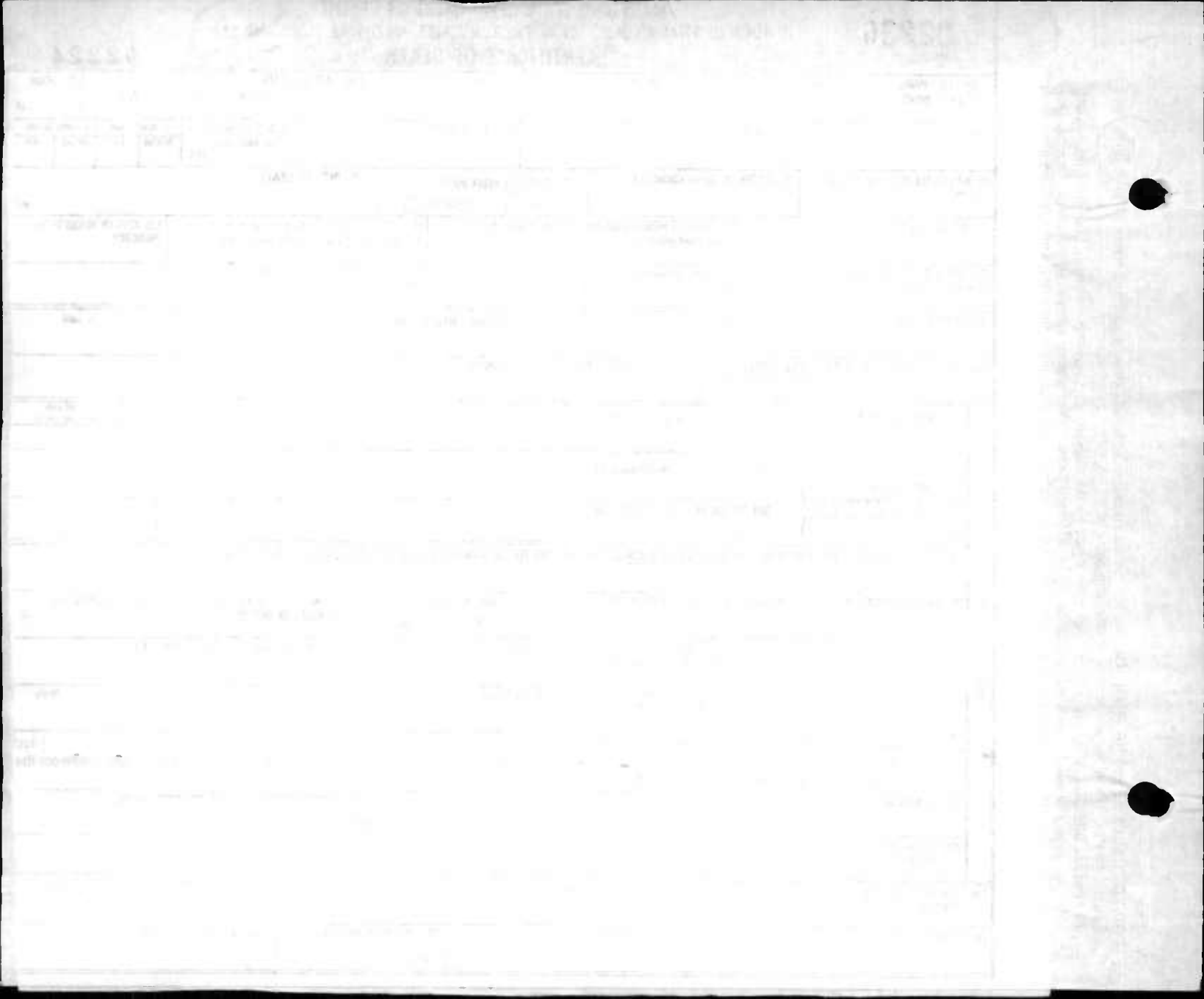
02224

|  |                             |   |   |
|--|-----------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>ELIZABETH C. KELLER</b>   |                             | 2. DATE AND HOUR OF DEATH<br><b>2-22-68</b> <b>11:30 P. M.</b>  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Balto Co</b><br><b>2 Thicket Road</b>  |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>C. CITY OR TOWN <b>Baltimore</b><br>E. STREET AND NUMBER <b>2 Thicket Road</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>9-15-1876</b>                                  |
| 9. AGE (In years last birthday)<br><b>91</b>   |                             | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John Smith</b>   |                             | 14. MOTHER'S MAIDEN NAME<br><b>Charlotte Clemens</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                             | 16. SOCIAL SECURITY NO.<br><b>-</b>   |   |
| 17. INFORMANT<br><b>Mrs. Harry W. Wright</b>   |                             | ADDRESS<br><b>Above</b>   |   |
| 18. <b>4129 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Anterior Myocardial Infarction</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>22. I certify that (I) (this hospital) attended the deceased from 1953 to 2/22 1968 that (I) (we) last saw the deceased alive on 2/19/68 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |
| 23A. SIGNATURE<br><b>Thomas L. Worsley</b><br>DEGREE   |                             | 23B. DATE SIGNED<br><b>2/23/68</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Thomas L. Worsley M.D.</b><br>DEGREE  |                             | 23D. ADDRESS<br><b>6505 York Road, Balto., Md. 21212</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>2-26-68</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Parkwood</b>   | 24D. LOCATION (City, town, or county) (State)<br><b>Parkville Md.</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>FEB 28 1968</b>  |                             | 25B. NAME OF REGISTRAR<br><b>Charles Judge</b>  |   |
| 25C. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>  |                             | ADDRESS<br><b>4905 York Rd.</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be retained by the funeral director.

VR A  
30M RI



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |  |   |  |  |   |  |  |  |
|--|--|------------------------------|--|--|---|--|--|---|--|--|--|
| 02237  |  |                              |  |  | 02225                                     |  |  |   |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |                              |  |  | 2a. DATE OF DEATH                         |  |  | 2b. HOUR                                      |  |  |  |
| First Middle Last<br><b>Edna E. Kennard</b>  |  |                              |  |  | Month Day Year<br><b>2 2 1968</b>         |  |  | 7 P M   |  |  |  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |   |  | 6. AGE (In years last birthday)  |   | IF UNDER 1 YEAR MONTHS DAYS  |  |  |
| Female   |  | White                        |  | 4-13-80 79   |   |  | 87 88 YRS.   |   | IF UNDER 24 HRS. HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |   |  |  |  |
| Md.  |  | U.S.A.                       |  |  |   | Baltimore Md.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| Catonsville  |  |                              | Spring Grove State Hosp  |  |   | housewife  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                         |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER   |  |  |
| Md.  |  |                              |  |  | Balto.                                    |  |  |   | 2207 Langley St.   |  |  |
| 14. FATHER'S NAME First Middle Last  |  |                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |  |  |   |  |  |  |
| Unknown Arbenna Bosson/  |  |                              | Unknown Edna /Malipendy  |  |   |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT                             |  |  |   |  |  |  |
|  |  |                              | 220-05-2321A   |  | Andrew Birmingham Address 2207 Langley St |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:   |  |                              |  |  |   |  |  |   |  |  |  |
| IMMEDIATE CAUSE (a) Cardiac insufficiency  |  |                              |  |  |   |  |  |   |  |  |  |
| 281.9 DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |   |  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anemia of unknown cause   |  |                              |  |  |   |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac arrest  |  |                              |  |  |   |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |   |  |  |   |  |  |  |
| 293X   |  |                              |  |  |   |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from Sept 26, 19 68, to Feb 21, 19 68, that (I) (we) last saw the deceased alive on Feb 21, 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |   |  |  |   |  |  |  |
| 22b. SIGNATURE Narciso Aristigueta   |  |                              |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |   | 22c. DATE SIGNED 2-22-68   |  |  |
| 22d. PHYSICIAN'S NAME (Type) NARCISO ARISTIGUETA   |  |                              |  |  |   | 22e. ADDRESS SPRING GROVE STATE HOSP.  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY        |  |  | 23d. LOCATION (City or Town) (County) (State) |  |  |  |
| Burial   |  |                              | 2/24/68  |  | Meadowridge Memorial Cem                  |  |  | Baltimore Md.                                 |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229  |  |                              |  |  |   | 25a. REC'D BY REGISTRAR DATE FEB 26 1968   |  |   | 25b. REGISTRAR'S SIGNATURE Charles Judge                             |  |  |

02237

02237

Number

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

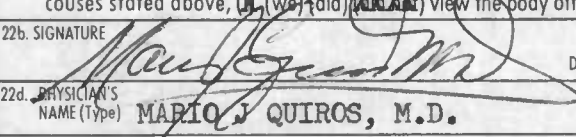

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| 022238  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| 022235  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>JOHN</b>  |  |  | Middle<br><b>ARNOLD</b>   |  |  | Last<br><b>KENNEDY</b>  |  |  | 2a. DATE OF DEATH<br>Month<br><b>FEBRUARY</b> Day<br><b>17</b> Year<br><b>1968</b>          |  |  | 2b. HOUR<br><b>10:35</b>                                |  |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br><b>9/20/94</b>  |  |  | 6. AGE (In years last birthday)<br><b>73</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS<br><b>73</b> DAYS<br><b>73</b>                                    |  |  | IF UNDER 24 HRS.<br>HOURS<br><b>73</b> MIN<br><b>73</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>HOSPITAL VETERANS ADMINISTRATION</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>YARD CLERK</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RAILROAD</b>  |  |  |   |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                     |  |  | 13e. STREET AND NUMBER<br><b>1248 WILLIAMS STREET</b>                                       |  |  |   |  |  |
| 14. FATHER'S NAME<br>First<br><b>JOHN</b>   |  |  | Middle<br><b>H</b>  |  |  | Last<br><b>KENNEDY</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>JANE</b>  |  |  | Middle<br><b>HOPKINS</b>  |  |  | Last<br><b>HOPKINS</b>                                  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>YES</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>705 05 6103</b>  |  |  | 17. INFORMANT<br>Address<br><b>CLINICAL RECORDS, VA HOSP, FT HOWARD, MD</b>   |  |  |   |  |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CEREBRAL INFARCT, RECENT</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ARTERIOSCLEROSIS</b>  |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hours</b><br><b>days</b><br><b>years</b> |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>CIRRHOSIS OF LIVER, LAENNEC'S TYPE</b>   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b>                                  |  |  |   |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |   |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2/17/68</b> , 19____, to <b>2/17/68</b> , 19____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/17/68</b> , 19____, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death. |  |  |   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>   |  |  |   |  |  |   |  |  |   |  |  | 22c. DATE SIGNED<br><b>2/18/68</b>  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MARIO J. QUIROS, M.D.</b>  |  |  |   |  |  |   |  |  |   |  |  | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>                                   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>2/20/68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK CEMETERY</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE MD</b>  |  |  |   |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>MCCULLY FUNERAL HOME, 130 E FORT AVE, BALTO, MD</b>   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>FFB 19 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |  |   |  |  |   |  |  |

03233

03233

DATE: 12/17/1968 TIME: 10:32

NAME: [REDACTED] ADDRESS: [REDACTED]

TELEPHONE: [REDACTED] MAILING ADDRESS: [REDACTED]

DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED]

EDUCATION: [REDACTED] OCCUPATION: [REDACTED]

RELIGION: [REDACTED] POLITICAL AFFILIATION: [REDACTED]

REASON FOR REQUEST: [REDACTED]

DATE OF REQUEST: [REDACTED]

DATE OF REVIEW: [REDACTED]

DATE OF APPROVAL: [REDACTED]

DATE OF CANCELLATION: [REDACTED]

DATE OF EXPIRATION: [REDACTED]

DATE OF RENEWAL: [REDACTED]

DATE OF REJECTION: [REDACTED]

DATE OF REINSTATEMENT: [REDACTED]

DATE OF REVOCATION: [REDACTED]

DATE OF SUSPENSION: [REDACTED]

DATE OF TERMINATION: [REDACTED]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02239

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02227

|  |         |   |  |  |  |   |  |  |  |                          |     |          |   |  |
|--|---------|---|--|--|--|---|--|--|--|--------------------------|-----|----------|---|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First   |  | Middle   |  | Last  |  | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED  |  | Month                    | Day | Year     | 2b. HOUR  |  |
| JOHN   |         | I.  |  | KERCHERVILLE   |  |   |  |  |  | 2/25                     | 19  | 68       | 7:45 P.   |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH  |  | 6. AGE (in years<br>last birthday)   |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS  |  | 2c. DATE PRONOUNCED DEAD |     | 2d. HOUR |   |  |
| male   | white   | 8/7/94  |  | 72 YRS.  |  | MONTHS  |  | DAYS   |  | February 25              |     | 7:45 P.  |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |         | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                 |  | 9. COUNTY OF DEATH  |  |  |  |                          |     |          |   |  |
| Montgomery Co., Md.  |         | U.S.A.  |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>              |  | Baltimore   |  |  |  |                          |     |          |   |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |  |  |  |                          |     |          |   |  |
| Ft. Howard   |         | Vet. Adm. Hospital  |  | unb  |  |   |  |  |  |                          |     |          |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER   |  |                          |     |          |   |  |
| Maryland   |         |   |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 9 S. Poppleton Street  |  |                          |     |          |   |  |
| 14. FATHER'S NAME  |         | First   |  | Middle   |  | Last  |  | 15. MOTHER'S MAIDEN NAME   |  | First                    |     | Middle   |   |  |
| George Kercherville  |         |   |  |  |  |   |  | Margaret Unknown   |  |                          |     |          |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |  |  |                          |     |          |   |  |
| Yes  |         | W.W.I   |  | 217-03-9384  |  | Mrs. Rose Marie Dominick  |  |  |  |                          |     |          |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bilateral Abscess Forming Pneumonia Complicating</u><br><u>988 X</u> <u>Cerebral Injury</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____   |         |   |  |  |  |   |  |  |  |                          |     |          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |   |  |  |  |   |  |  |  |                          |     |          |   |  |
| 19a. DATE OF OPERATION   |         |   |  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                                       |  |   |  | 20. AUTOPSY?   |  |                          |     |          |   |  |
|  |         |   |  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |                          |     |          |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH   |         |   |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 11/6/ 19 67                      |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Subj. beaten about head (found) |  |                          |     |          |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |         |   |  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.)<br>home    |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Baltimore, Maryland                                |  |                          |     |          |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |         |   |  |  |  |   |  |  |  |                          |     |          |   |  |
| ACTUAL<br>SIGNATURE <u>Werner U. Spitz</u>   |         |   |  | M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |                          |     |          |   |  |
| EXAMINER'S<br>NAME (Type)  |         |   |  | Werner U. Spitz, M.D.  |  |   |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |                          |     |          |   |  |
|  |         |   |  |  |  |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |                          |     |          |   |  |
|  |         |   |  |  |  |   |  | ADDRESS (Street, city, town, or county)  |  |                          |     |          |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         |   |  | 23b. DATE  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                          |     |          |   |  |
| Burial   |         |   |  | 2/29/68  |  |   |  | Baltimore National   |  |                          |     |          |   |  |
|  |         |   |  |  |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.  |  |                          |     |          |   |  |
| 24. FUNERAL DIRECTOR   |         |   |  | ADDRESS  |  |   |  | 25a. REC'D BY REGISTRAR  |  |                          |     |          |   |  |
| Joseph N. Zannino  |         |   |  | 263 S. Conkling Street   |  |   |  | FEB 27 1968  |  |                          |     |          |   |  |
|  |         |   |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |                          |     |          |   |  |

03330

03330

03330

( ) \*

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                      |  |  |   |   |              |   |   |   |           |  |                                      |                                   |   |  |
|---|--|----------------------|--|--|---|---|--------------|---|---|---|-----------|--|--------------------------------------|-----------------------------------|---|--|
| 02240   |  | CERTIFICATE OF DEATH |  |  |   |   |              | 02228   |   |   |           |  |                                      |                                   |   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |                      | First<br>MARION  |  | Middle<br>V.  |   | Last<br>KING |   | 2a. DATE OF DEATH<br>Month<br>February  |   | Day<br>3, |  | Year<br>1968                         |                                   | 2b. HOUR<br>noon                                |  |
| 3. SEX<br>Female  |  |                      | 4. RACE<br>White   |  |   | 5. DATE OF BIRTH<br>September - , 1885  |              |   | 6. AGE (In years<br>lost birthday)<br>82 YRS.   |   |           | IF UNDER 1 YEAR<br>MONTHS<br>DAYS                  |                                      | IF UNDER 24 HRS.<br>HOURS<br>MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Virginia  |  |                      | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |              |   | 9. COUNTY OF DEATH<br>Baltimore 4   |   |           |  |                                      |                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Joseph Hospital |  |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Homemaker   |              |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |           |  |                                      |                                   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  |                      | 13b. COUNTY<br>Baltimore   |  |   | 13c. CITY OR TOWN<br>Baltimore  |              |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |           | 13e. STREET AND NUMBER<br>918 East Lake Ave. 21212 |                                      |                                   |   |  |
| 14. FATHER'S NAME<br>First<br>Middle<br>Last<br><del>Anderson</del> Charles H. Bray   |  |                      | 15. MOTHER'S MAIDEN NAME<br>First<br>Middle<br>Last<br><del>Anderson</del> Mary A. Lee                 |  |   |   |              |   |   |   |           |  |                                      |                                   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)<br>no   |  |                      | 16b. SOCIAL SECURITY NO.   |  |   | 17. INFORMANT<br>Hospt. Records.  |              |   | Address   |   |           |  |                                      |                                   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>4330 IMMEDIATE CAUSE (a) HYPERTENSIVE ENCEPHALOPATHY<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) GENERALIZED ARTERIOSCLEROSIS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>334x |  |                      |  |  |   |   |              |   |   |   |           |  |                                      |                                   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| 19a. DATE OF OPERATION  |  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |              |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |   |           |  |                                      |                                   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                      | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |              |   |   |   |           |  |                                      |                                   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |                      | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |              |   |   |   |           |  |                                      |                                   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from December 30 1967, to February 3 1968, that (I) (we) last saw the deceased alive on February 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |                      |  |  |   |   |              |   |   |   |           |  |                                      |                                   |   |  |
| 22b. SIGNATURE<br>Dr. Gualberto C. Gokim, Jr. DEGREE  |  |                      |  |  |   |   |              |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |           |  | 22c. DATE SIGNED<br>February 3, 1968 |                                   |   |  |
| 22d. PHYSICIAN'S NAME (Type) Dr. Gualberto C. Gokim, Jr.  |  |                      |  |  |   |   |              |   |   | 22e. ADDRESS<br>7620 York Road, Baltimore, Md. 21204  |           |  |                                      |                                   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |                      | 23b. DATE<br>2/6/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cem. |   |              | 23d. LOCATION (City or Town) (County) (State)<br>Balto. |   |   |           |  |                                      |                                   |   |  |
| 24. FUNERAL DIRECTOR<br>Mitchell-Wiedefeld Home-6500 York Rd. 21212   |  |                      |  |  |   |   |              |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 8 1968  |           | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge        |                                      |                                   |   |  |

03280

03280

03280

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |                                    |   |      |   |  |  |          |                                |  |                                |  |
|--|--|--|--|--|------------------------------------|---|------|---|--|--|----------|--------------------------------|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                                    |   |      |   |  |  |          |                                |  |                                |  |
| CERTIFICATE OF DEATH   |  |  |  |  |                                    |   |      |   |  |  |          |                                |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  |  | Middle                             |   | Last |   | 2a. DATE OF DEATH  |  | 2b. HOUR |                                |  |                                |  |
| MARY,  |  |  | G.   |  | KING                               |   |      |   | Feb. 24, 1968  |  | 4:50 PM  |                                |  |                                |  |
| 3. SEX   |  |  | 4. RACE  |  |                                    | 5. DATE OF BIRTH  |      |   | 6. AGE (In years last birthday)  |  |          | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| Female   |  |  | White  |  |                                    | June 6, 1934  |      |   | 33 YRS.  |  |          |                                |  |                                |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   | 9. COUNTY OF DEATH   |  |          |                                |  |                                |  |
| Md.  |  |  | U.S.A.   |  |                                    |   |      |   | Balto.   |  |          | Md.                            |  |                                |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |      |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |                                |  |                                |  |
| Balto.   |  |  | St. Joseph Hospital  |  |                                    |   |      |   |  |  |          |                                |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN   |      |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |          | 13e. STREET AND NUMBER         |  |                                |  |
| Md.  |  |  | Balto.   |  |                                    | Balto.  |      |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |  |          | 104 Rosewood Ave. 21228        |  |                                |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |                                    |   |      |   |  |  |          |                                |  |                                |  |
| First Middle Last  |  |  | First Middle Last  |  |                                    |   |      |   |  |  |          |                                |  |                                |  |
| WALTER   |  |  | Bellis   |  |                                    | CATHERINE   |      |   | Morseberger  |  |          |                                |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT   |      |   | Address  |  |          |                                |  |                                |  |
|  |  |  |  |  |                                    | FRANCIS D. KING   |      |   | 104 Rosewood Ave 21228   |  |          |                                |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hodgkins Disease Terminal</u><br>201X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |                                    |   |      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |                                |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>201X   |  |  |  |  |                                    |   |      |   |  |  |          |                                |  |                                |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |          |                                |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |   |  |  |          |                                |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |      |   |  |  |          |                                |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 22, 1968</u> , to <u>Feb. 24, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 24, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |  |  |                                    |   |      |   |  |  |          |                                |  |                                |  |
| 22b. SIGNATURE <u>Antonio G. de Leon M.D.</u>  |  |  |  |  |                                    | 22c. DATE SIGNED<br>Feb. 24, 1968   |      |   |  |  |          |                                |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Antonio deLeon M.D.  |  |  |  |  |                                    | 22e. ADDRESS<br>St. Joseph Hospital   |      |   |  |  |          |                                |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |      | 23d. LOCATION (City or Town) (County) (State) |  |  |          |                                |  |                                |  |
| BURIAL   |  |  | 2/28/68  |  | Balto. National Cem.               |   |      | Balto. Md                                     |  |  |          |                                |  |                                |  |
| 24. FUNERAL DIRECTOR<br>E.S. Mac Nabbs   |  |  |  |  |                                    | ADDRESS<br>Catonsville Md   |      |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 29 1968  |  |          |                                |  |                                |  |
|  |  |  |  |  |                                    | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>  |      |   |  |  |          |                                |  |                                |  |

3333

10/10/10

10/10/10

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|--|--|--|--|
| 02242  |  |  |  |   |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |  |  |  |  | 02230               |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Julia May KIRBY  |  |  |  |   |  |  |  |  |  |  |  | 2a. DATE OF DEATH Month Day Year<br>2 14 68  |  |  |  |   |  |  |  |  |  |  |  | 2b. HOUR<br>7:10 AM |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Female   |  |  |  | 4. RACE<br>White  |  |  |  | 5. DATE OF BIRTH<br>11/18/04   |  |  |  | 6. AGE (In years lost birthday)<br>65 YRS.   |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                     |  |  |  | IF UNDER 24 HRS. HOURS MIN                         |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Wash., D.C.   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Owings Mills  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Rosewood State Hospital |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>dependent   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>none  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  |  | 13b. COUNTY<br>Prince George  |  |  |  | 13c. CITY OR TOWN<br>St. Pleasant  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 13e. STREET AND NUMBER<br>526-69th Street, N.E. |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Joseph Kirby  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Katherine Cage  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)<br>no   |  |  |  | (If yes give war or dates of service)<br>--   |  |  |  | 16b. SOCIAL SECURITY NO.<br>none   |  |  |  | 17. INFORMANT Address<br>Rosewood Records, Owings Mills, Maryland  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Neurotizing bronchial pneumonia</u><br>4441<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4547</u><br>(b) <u>Multiple Cerebral infarctions</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Aortic + Common Carotid thrombosis</u> |  |  |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>10 days,</u><br><u>1 1/2 yrs,</u><br><u>1 1/2 yrs.</u>                              |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>Severe mental retardation etiology undetermined, congenital.</u>   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes   |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>59</u> , to <u>2/14</u> , 19 <u>68</u> , that (X) (we) lost saw the deceased alive on <u>2/14</u> , 19 <u>68</u> , and that in (no) (our) opinion death occurred on the date and hour and from the causes stated above (X) (we) did (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Richard A. Jones</u>  |  |  |  |   |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>2/14/68                     |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Richard A. Jones, M.D.   |  |  |  |   |  |  |  |  |  |  |  | 22e. ADDRESS<br>Rosewood St. Hosp., Owings Mills, Md.  |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |  |  | 23b. DATE<br>2-16-1968  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Epiphany   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Frederickville Prince Georges   |  |  |  |   |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>W. H. Murphy</u>  |  |  |  |   |  |  |  |  |  |  |  | ADDRESS<br>131-11th St. S.E. D.C.  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 16 1968     |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u> |  |  |  |                     |  |  |  |  |  |  |  |  |  |  |  |

nr:536

4550

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02243

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                         |  |   |   |  |   |  |  |  |
|--|-------------------------|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>VIOLA B. KOLB</b>   |                         |  | 2a. DATE KNOWN OF ESTI-<br>MATED <b>2-3</b> 1968                |   |  | 2b. HOUR <b>11:52</b> AM  |  |  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Cauc.</b> | 5. DATE OF BIRTH<br><b>5/6/16</b>  | 6. AGE (In years last birthday)<br><b>51</b> YRS.               | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>  | 2c. DATE PRONOUNCED DEAD<br>Month <b>2</b> - Day <b>3</b> - Year <b>68</b> 19 |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore County</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Hicksville Kilm Co.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Saleswoman</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dept. Store</b>                                      |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>  |                         |  | 13b. COUNTY <b>Baltimore</b>                                    |   | 13c. CITY OR TOWN<br><b>Baltimore County</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>521 South 46th St.</b>  |                         |  |   |   |  |   |  |  |  |
| 14. FATHER'S NAME<br><b>Guy Hilditch</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br><b>Nellie Lutz</b>                  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                         |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-4357</b>                  |   | 17. INFORMANT<br><b>Joseph Kolb</b>  |   |  | ADDRESS<br><b>521 South 46th St.</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>410.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>A-S-C-V-Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>_____ |                         |  |   |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4201</b>   |                         |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b> |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>    |                         |  |   |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>M.B. Davis</b>  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                 |   |  | 22b. DATE SIGNED<br><b>2/4/68</b>   |  |  |  |
| EXAMINER'S NAME (Type)<br><b>M.B. Davis MD</b>   |                         |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>             |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         |  | 23b. DATE<br><b>2/7/68</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Inc.</b>  |                         |  | ADDRESS<br><b>Baltimore, MD. 21202</b>                          |   |  | 25a. REC'D BY REGISTRAR<br><b>FEB 6 1968</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

03331

03331  
UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



RECEIVED  
JAN 10 1910  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

RECEIVED  
JAN 10 1910  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22 File 398  
2-28-68 ams  
02244  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
02232

|  |  |   |  |  |  |  |  |   |  |   |  |
|--|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>FREDERICK</b>   |  | First   |  | Middle   |  | Last   |  | 2a. DATE KNOWN OF ESTI-DEATH <input checked="" type="checkbox"/> Month <b>Feb.</b> Day <b>4,</b> Year <b>1968</b> |  | 2b. HOUR a.m. <b>2:15</b>                     |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH <b>1954</b>   |  | 6. AGE (In years last birthday) <b>13</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS<br>HOURS <b></b> MIN. <b></b> |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b>  |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Feb.</b> Day <b>4,</b> Year <b>1968</b>                                      |  | 2d. HOUR a.m. <b>2:15</b>                     |  |
| 10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rolling Rd. South of Edmonson Avenue</b>    |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>STUDENT</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>CATONSVILLE</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>325 Whitfield Road</b>  |  |   |  |
| 14. FATHER'S NAME <b>FRED</b>  |  | First   |  | Middle <b>G.</b>   |  | Last   |  | 15. MOTHER'S MAIDEN NAME <b>MARY JO</b>   |  | First <b>RICE</b>                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b></b>   |  | 16b. SOCIAL SECURITY NO. <b></b>  |  | 17. INFORMANT <b>Dr. Fred B. Kraft Jr.</b>   |  | ADDRESS <b>- 325 Whitfield Rd.</b>   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxia due to aspiration of gastric content</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>816.9</b><br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b>                                 |  |   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>823.4</b>   |  |   |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION <b></b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Unkxxx</b>  |  | 21b. TIME OF INJURY Month, Day, Year <b>2-4 1968</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Car struck telephone pole</b>   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street Rolling Rd. So. of Edmondson Ave</b> |  | 21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b>Balto.</b> State <b>Md.</b>   |  |  |  |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Werner U. Spitz</b>  |  | EXAMINER'S NAME (Type) <b>Werner U. Spitz M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                               |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  | 22b. DATE SIGNED <b>2-4-68</b>                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>2-7-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cem.</b>  |  | 23d. LOCATION (City or Town) <b>Baltimore</b> (County) <b>Md.</b> (State) <b></b>            |  |   |  |   |  |
| 24. FUNERAL DIRECTOR <b>Foley, Conway &amp; FN. - Catonsville, Md</b>  |  | ADDRESS <b></b>   |  | 25a. REC'D BY REGISTRAR <b>FEB 8 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |   |  |   |  |

95336

1230

FOR STATE  
HONORARY

UNITED STATES DEPARTMENT OF AGRICULTURE

UNITED STATES DEPARTMENT OF AGRICULTURE

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |         |  |        |   |                                |   |   |   |  |                         |
|--|---------|--|--------|---|--------------------------------|---|---|---|--|-------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |  |        |   |                                |   |   |   |  |                         |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |         |  |        |   |                                |   |   |   |  |                         |
| 1. DECEASED-NAME<br>(Type or Print)  |         |  | First  |   | Middle                         |   | Last  |   |  |                         |
| BRIAN  |         |  | JOSEPH |   | KUKLA                          |   |   |   |  |                         |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)   | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN.  |   | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 2/2/ | 2b. HOUR<br>12<br>A M   |
| male   | white   | Dec. 12, 1967  |        | - YRS. 1  | 21                             |   |   |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>February 2, 1968                     | 2d. HOUR<br>7:00<br>A M |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                | 9. COUNTY OF DEATH  |   |   |  |                         |
| Maryland   |         | U.S.A.   |        |   |                                | Baltimore Md.   |   |   |  |                         |
| 10. CITY OR TOWN OF DEATH  |         |  |        | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |                                |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                         |
| Towson   |         |  |        | St. Joseph's  |                                |   | None  |   |  |                         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |  |        | 13b. COUNTY   |                                | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER   |                         |
| Maryland   |         |  |        | Baltimore   |                                | Baltimore   |   | 2418 Bridgehampton Apts.  |  |                         |
| 14. FATHER'S NAME  |         |  | First  |   | Middle                         |   | Last  |   |  |                         |
| Frank  |         |  | George |   | Kukla                          |   |   |   |  |                         |
| 15. MOTHER'S MAIDEN NAME   |         |  | First  |   | Middle                         |   | Last  |   |  |                         |
| Kathy  |         |  | Marie  |   | O'Brien                        |   |   |   |  |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         |  |        | 16b. SOCIAL SECURITY NO.  |                                | 17. INFORMANT ADDRESS   |   |   |  |                         |
| No   |         |  |        | None  |                                | Mr. Frank G. Kukla 2418 Apt F Bridgehampton Dr                                  |   |   |  |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |        |   |                                |   |   |   |  |                         |
| PART 1. DEATH WAS CAUSED BY:   |         |  |        |   |                                |   |   |   |  |                         |
| IMMEDIATE CAUSE (a) <u>Interstitial Pneumonitis (SDII)</u>   |         |  |        |   |                                |   |   |   |  |                         |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |   |                                |   |   |   |  |                         |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |        |   |                                |   |   |   |  |                         |
| (b)  |         |  |        |   |                                |   |   |   |  |                         |
| DUE TO, OR AS A CONSEQUENCE OF   |         |  |        |   |                                |   |   |   |  |                         |
| (c)  |         |  |        |   |                                |   |   |   |  |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         |  |        |   |                                |   |   |   |  |                         |
| 7630   |         |  |        |   |                                |   |   |   |  |                         |
| 19a. DATE OF OPERATION   |         |  |        | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |                                |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |                         |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |         |  |        | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19  |                                | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |  |                         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |        | 21f. LOCATION Street or R.F.D. No.  |                                | City or Town  |   | County  | State  |                         |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |        |   |                                |   |   |   |  |                         |
| ACTUAL SIGNATURE <u>Werner U. Spitz</u>  |         |  |        | M.D.  |                                | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                 |   | 22b. DATE SIGNED  |  |                         |
| EXAMINER'S NAME (Type)   |         |  |        | Werner U. Spitz, M.D.   |                                | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                |   | 2/2/68  |  |                         |
| ADDRESS (Street, city, town, or county)  |         |  |        |   |                                |   |   |   |  |                         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                                | 23d. LOCATION (City or Town) (County) (State)                                   |   |   |  |                         |
| Burial   |         | 2/3/68   |        | Dulaney Valley Cemeetry   |                                | Cockeysville, Maryland  |   |   |  |                         |
| 24. FUNERAL DIRECTOR   |         |  |        | ADDRESS   |                                | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |                         |
| Wm. Cook-Brooks Towson 1050 York Rd. 21204   |         |  |        |   |                                | FEB 9 1968  |   | <u>Charles Judge</u>  |  |                         |

71243955

03333

03333

03333



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |   |   |   |   |   |  |
|---|--|--|---|---|---|---|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |   |   |   |   |   |  |
| CERTIFICATE OF DEATH  |  |  |   |   |   |   |   |   |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Fannie Lambdin</b>   |  |  | First Middle Last   |   |   | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>7</b> Year <b>68</b>                                       |   | 2b. HOUR<br><b>8:30</b> A M                                     |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br><b>Jan. 28, 1885</b>  |   | 6. AGE (In years last birthday)<br><b>83</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Balto.</b> Md.   |   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Bloomsbury N. H.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>---</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>                 |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>4701 Dartford Avenue</b> |  |
| 14. FATHER'S NAME First Middle Last<br><b>Charles <del>WITZKE</del> Lambdin</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Frances Lambdin</b>  |   |   |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>none</b>   |   | 17. INFORMANT<br><b>Mrs. Carroll Sparks, 4701 Dartford Avenue, Baltimore, Md. 21229</b> |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC C-V DISEASE</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>HYPERTENSIVE ART. SCLER. C-V DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 YEARS.</b><br><b>12 YEARS</b> |  |  |   |   |   |   |   |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>443X ACUTE VIRAL INFLUENZA &amp; PNEUMONIA, LEFT BASE</b>   |  |  |   |   |   |   |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> , 19 <b>67</b> , to <b>2/7</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |   |   |   |   |   |  |
| 22b. SIGNATURE<br><b>Paul R. Ziegler MD</b> DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |   |   | 22c. DATE SIGNED<br><b>2/8/68</b>   |   |   |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Paul Ziegler</b>   |  |  |   |   |   | 22e. ADDRESS<br><b>200 CHESTNUT HILL DR. ELICOTT CITY, MD.</b>  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-9-68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                                    |   |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Witzke Funeral Directors, 4101 Edmondson Avenue, Balto., Md. 21229</b>   |  |  |   |   |   | 25a. REC'D BY REGISTRAR<br><b>FEB 8 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>              |   |  |

02286

02286

02286

Female

Male

Female

Male

Female

Female

Male



02286



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02247   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 02235  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | First Middle Last   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| John  |  |  |  |  |  |  |  |  |  | H. Lancaster  |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | 10:25 p.m.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday)   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |  |  |  |  |  |  |
| Male  |  |  |  |  |  |  |  |  |  | White   |  |  |  |  |  |  |  |  |  | 8-28-1905  |  |  |  |  |  |  |  |  |  | 62 YRS.   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  |  |  |  |  |  | Md.                         |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Baltimore Co.   |  |  |  |  |  |  |  |  |  | U.S.A.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Perry Hall  |  |  |  |  |  |  |  |  |  | 4123 Cliffvale Rd   |  |  |  |  |  |  |  |  |  | Shovel operator  |  |  |  |  |  |  |  |  |  | C. B. Temple  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Md.   |  |  |  |  |  |  |  |  |  | Baltimore   |  |  |  |  |  |  |  |  |  | Perry Hall   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 21236                       |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | First Middle Last   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Charles L. Lancaster  |  |  |  |  |  |  |  |  |  | Emma H. Borin   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  |  |  |  |  |  | 217-07-3423   |  |  |  |  |  |  |  |  |  | Mrs Earl S. Lancaster  |  |  |  |  |  |  |  |  |  | 4123 Cliffvale Road   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)   |  |  |  |  |  |  |  |  |  | Acute Myocardial Infarction   |  |  |  |  |  |  |  |  |  | Immediate  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 4109  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  | Generalized Coronary Arteriosclerosis  |  |  |  |  |  |  |  |  |  | 10 years  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | (b)   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 4201 Emphysema, Chronic Bronchitis  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner) |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.                             |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | 19  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>                    |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Theodore E. Evans, M. D.  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED  |  |  |  |  |  |  |  |  |  | 2-20-68  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Theodore E. Evans, M. D.  |  |  |  |  |  |  |  |  |  | 9660 Belair Rd., 21236  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | 2-23-1968   |  |  |  |  |  |  |  |  |  | St. Michael's Cemetery   |  |  |  |  |  |  |  |  |  | Baltimore Co. Md.   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Lassahn Funeral Home  |  |  |  |  |  |  |  |  |  | 7401 Belair Rd  |  |  |  |  |  |  |  |  |  | DATE FEB 23 1968   |  |  |  |  |  |  |  |  |  | Charles Judge   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02248

02236

|   |  |   |  |   |   |   |   |  |                                |   |                                |  |
|---|--|---|--|---|---|---|---|--|--------------------------------|---|--------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br><b>JOHN</b>  |  | Middle<br><b>E.</b>   |   | Last<br><b>LANE</b>   |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>FEBRUARY 10 1968</b>       |                                |   | 2b. HOUR<br><b>12:15 PM</b>    |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>NEGRO</b>   |  | 5. DATE OF BIRTH<br><b>MAY 3, 1913</b>  |   |   | 6. AGE (In years last birthday)<br><b>54</b> YRS.                                 |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |   |  |                                |   |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                                |   |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>SOMERSET</b>  |  | 13c. CITY OR TOWN<br><b>CRISFIELD</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>139 1/2 S. 4th Street</b>               |                                |   |                                |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>JOHN E LONDON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>DORA H MORGAN</b>   |  |   |   |   |   |  |                                |   |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>YES</b> (If yes give war or dates of service) <b>WW II</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216 07 1754</b>  |  | 17. INFORMANT<br>Address<br><b>CLINICAL RECORDS, VA HOSP, FORT HOWARD, MD</b>   |   |   |   |  |                                |   |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1621</b><br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA TERMINAL</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF LUNGS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>UNKNOWN</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |   |   |   |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b> |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>163X</b>   |  |   |  |   |   |   |   |  |                                |   |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |   |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |                                |   |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |   |  |                                |   |                                |  |
| 22a. I certify that <b>X</b> (this hospital) attended the deceased from <b>11/1/67</b> , 19__, to <b>2/10/68</b> , 19__, that <b>X</b> (we) last saw the deceased alive on <b>2/10/68</b> , 19__, and that in <b>MD</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>X</b> (we) (did) <b>(not)</b> view the body after death.  |  |   |  |   |   |   |   |  |                                |   |                                |  |
| 22b. SIGNATURE<br><b>Madhav D. Barhanpurkar</b>   |  | 22c. DATE SIGNED<br><b>2/11/68</b>  |  |   |   |   |   |  |                                |   |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>MADHAV D. BARHANPURKAR, M.D.</b>   |  | 22e. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>   |  |   |   |   |   |  |                                |   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/14/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Asbury Cemetery</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Somerset County, Maryland</b> |  |                                |   |                                |  |
| 24. FUNERAL DIRECTOR<br><b>Arthur E. Ward Funeral Home, Crisfield, Md.</b>  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>FEB 14 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>William J. Judge</b>   |   |  |                                |   |                                |  |

02224

02224

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

MAY 3, 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02249   |  |  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 02237  |  |   |  |
|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Lillian Maude</b> <b>League</b>  |  |  |  | 2a. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>29</b> Year <b>68</b>  |  |   |  | 2b. HOUR<br><b>8:30</b> <b>PM</b>                                    |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>APRIL 19, 1980</b>  |  | 6. AGE (In years lost birthday)<br><b>87</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN                               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Garrison</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Foxleigh Nursing Home</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Balto</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3627 Marriotts Lane 21207</b>           |  |   |  |
| 14. FATHER'S NAME<br>First <b>Henry</b> Middle <b>Hildt</b> Last <b>Hutchins</b>  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Hannah</b> Middle <b>E.</b> Last <b>Hutchins</b>                        |  |  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-54-1831</b>   |  | 17. INFORMANT<br>Address <b>Mr. Howard Hughes 3627 Marriotts Lane 21207</b>  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b><br><b>428X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>A. few diseases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>cardiomyopathy</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>days</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>2201</b>  |  |  |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State  |  |   |  |  |  |   |  |
| 22a. I certify that (U) (this hospital) attended the deceased from <b>10-12</b> , 19 <b>67</b> , to <b>2-29</b> , 19 <b>68</b> , that (U) (we) lost<br>saw the deceased alive on <b>2-28</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |  |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>David J. Miller</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>   |  | MED. DIRECTOR <input type="checkbox"/>  |  | STAFF PHYS. <input type="checkbox"/>                                 |  | 22c. DATE SIGNED<br><b>2/29/68</b>                          |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>David J. Miller</b>  |  | 22e. ADDRESS<br><b>Leason Rd. Owings Mills, Md</b>   |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/2/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Durid Ridge Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville Balto Co Md</b>                  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Spring Byers 8728 Liberty Rd Randalltown</b>   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br><b>DATE MAR 4 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |   |  |



0330

0330

William James

29

28

27

William James

U.S.A.

U.S.A.

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston

Portland, Maine, Boston



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02250   |  |   |  | MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |                   |  | 02238    |  |  |  |
|---|--|---|--|---|--|---|--|---|--|-------------------|--|----------|--|--|--|
| Item 13a,b,c,&e Film G398 2/28/68   |  |   |  | CERTIFICATE OF DEATH  |  |   |  |   |  |                   |  |          |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First   |  | Middle  |  | Last  |  | 2a. DATE OF DEATH   |  |                   |  | 2b. HOUR |  |  |  |
| Marion  |  | Paige   |  | Leake   |  | February 15 1968  |  |   |  | 3.35AM            |  |          |  |  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>lost birthday)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.  |  |          |  |  |  |
| Female  |  | White   |  | 4-29-1882   |  | 85 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.        |  |          |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |   |  |                   |  |          |  |  |  |
| New Jersey  |  | U.S.A   |  |   |  | Baltimore   |  |   |  | Md.               |  |          |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |  |                   |  |          |  |  |  |
| Lutherville   |  | College Manor Nursing Home  |  | House Wife  |  | Own Home  |  |   |  |                   |  |          |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |                   |  |          |  |  |  |
| New York Md.  |  | Balto   |  | Lutherville   |  |   |  | 200 E. 66th Street  |  |                   |  |          |  |  |  |
| 14. FATHER'S NAME   |  | First   |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME  |  | First Middle Last |  |          |  |  |  |
| Eugene  |  | Paige   |  |   |  | Ada   |  | Bancroft  |  |                   |  |          |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  | Address   |  |   |  |                   |  |          |  |  |  |
| No  |  |   |  | Eugene W. Leake, Jr.  |  | Garrison, Md.   |  |   |  |                   |  |          |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Massive CVA</u><br>4369<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. <u>arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u> |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>18 hrs.                  |  |                   |  |          |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>331X <u>ROKE</u>  |  |   |  |   |  |   |  |   |  |                   |  |          |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |   |  |                   |  |          |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |                   |  |          |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |                   |  |          |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from September, 19 67, to 2/15, 19 68, that (I) (we) last<br>saw the deceased alive on 2/15 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |   |  |                   |  |          |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED  |  | 22d. PHYSICIAN'S<br>NAME (Type) WILLIAM F. FRITZ, M.D.  |  | 22e. ADDRESS  |  |   |  |                   |  |          |  |  |  |
| William F. Fritz  |  | 2/16/68   |  |   |  | 2 W. University Pkwy. Balto. 18, Md.  |  |   |  |                   |  |          |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |   |  |                   |  |          |  |  |  |
| Cremation   |  | 2/15/68   |  | Greenmount  |  | Baltimore, Md.  |  |   |  |                   |  |          |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |   |  |                   |  |          |  |  |  |
| H.W. Jenkins & Sons Co.   |  | DATE Feb 15 1968  |  | Charles Judge   |  |   |  |   |  |                   |  |          |  |  |  |
| 4905 York Road  |  |   |  |   |  |   |  |   |  |                   |  |          |  |  |  |
| Balto. 12, Md.  |  |   |  |   |  |   |  |   |  |                   |  |          |  |  |  |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

02251

02239

|   |                                  |   |   |  |   |   |                                |
|---|----------------------------------|---|---|--|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Baltimore</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |   |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>1 1/2 years</b> |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore (Cockeysville)</b> |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Mercy Villa Nursing Home</b>   |                                  |   |   | d. STREET ADDRESS<br><b>33 Cedar Knoll Road</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                              |                                |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elizabeth</b> Middle <b>Rolle</b> Last <b>Lehner</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>18</b> Year <b>1968</b>   |   |   |                                |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 12, 1893</b>    |  | 9. AGE (In years lost birthday)<br><b>74</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |                                |
| 13. FATHER'S NAME<br><b>Christopher Cunningham</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Louise Parr</b>   |   |   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>219-30-6552</b>   |   | 17. INFORMANT Address <b>Mercy Villa</b><br><b>Sister M. Carlotta, R.S.M., 6400 Bellona Ave.</b>   |   |   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio-Vascular Disease</b><br><b>2509</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO<br>(c) _____ |                                  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b><br><b>10 years</b>   |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>260X</b>  |                                  |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that (I) (this hospital) attended the deceased from <b>October 1</b> , 19 <b>67</b> , to <b>Feb. 17</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-17</b> , 19 <b>68</b> , and that death occurred at <b>8 A.</b> M, from causes and on the date stated above.  |                                  |   |   |  |   |   |                                |
| 22a. SIGNATURE<br><i>Philip H. Lynn M.D.</i>  |                                  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |   | 22b. DATE SIGNED<br><b>2-19-68</b>  |                                |
| 22c. PHYSICIAN'S NAME (Type)  |                                  |   |   | 22d. ADDRESS   |   |   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>2/21/1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemt. Baltimore, Md.</b>  |   | 23d. LOCATION (City or Town) (County) (State)   |                                |
| 24. FUNERAL DIRECTOR<br><b>Mitchell- Wiedefeld Home</b>   |                                  |   |   | ADDRESS<br><b>6500 York Rd.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 21 1968</b>  |                                |
|   |                                  |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Jones</i>   |   |   |                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

32551

STATE OF DEL.

02229

Baltimore

Baltimore

Baltimore

Baltimore (Cockeysville)

17 years

Baltimore

33 Cedar Knoll Road

Worcester Villa Nursing Home

February 19, 68

Letter

Elizabeth Kolia

August 12, 1968

Wife

Female

United States

Baltimore, Maryland

Housewife

Louise Hart

Christopher Cunningham

Barry Allen

119-70-5552 State A. Barlow, R.S.M., 2410 Calton Ave.

119-70-5552

40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH<br>Month Day Year                |  | 2b. HOUR<br>M   |  |
| FLORENCE   |  | S.   |  | LESCALLETTE   |  |   |  | February 19  |  | 11 P  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |  | IF UNDER 24 HRS.<br>HOURS MIN   |  |
| Female   |  | White  |  | May 3, 1905   |  | 82  |  |  |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |   |  |
| Baltimore, Md.   |  | USA  |  |   |  | Baltimore   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |   |  |
| Essex (21)   |  | 1612 Rickenbacker Rd.  |  | Housewife   |  | Home  |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                             |  |   |  |
| Md.  |  | Baltimore  |  | Essex (21)  |  |   |  | 1612 Rickenbacker Rd.                              |  |   |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last   |  |   |  |  |  |   |  |
| Samuel Moore   |  |  |  | Alvina  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address   |  |  |  |   |  |
| No   |  |  |  | Robert Lescallette  |  | Same  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arteriosclerotic Cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>2 yrs</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>4201</u>  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |   |  |
|  |  |  |  |   |  |   |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |   |  |
|  |  |  |  |   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |   |  |
|  |  |  |  |   |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1967</u> , to <u>Feb 19, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 18, 1968</u> and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>M. Baumgradner</u>  |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><u>2/20/68</u>  |  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>M. Baumgradner, M.D.</u>  |  | 22e. ADDRESS<br><u>8552 Philadelphia Rd. Balto. Md. 21237</u>                |  |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br><u>2/23/68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Holly Hill Memorial Gardens</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                          |  |  |  |   |  |
|  |  |  |  |   |  |   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>James E. Bruzdinski</u>   |  |  |  | ADDRESS<br><u>1407 Eastern Ave.</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>FEB 27 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u> |  |   |  |

8330

8330

8330

8330



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 02253  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 02241   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>George  |  | Middle<br>Maxwell   |  | Last<br>LESTER  |  | 2a. DATE OF DEATH<br>Month Day Year<br>February 20, 1968             |  | 2b. HOUR<br>9:15AM                           |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>May 6, 1920   |  | 6. AGE (In years last birthday)<br>47 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                             |  | IF UNDER 24 HRS.<br>HOURS MIN                |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore, Md.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>ST. JOSEPH HOSPITAL                |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Steel worker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth Steel   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Essex  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>129 Riverside Rd.                          |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>George Lester  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Jean Frye   |  |   |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>WW11 244 16 8853   |  | 17. INFORMANT<br>M. Irene Lester Same Address   |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109 Massive recurrent myocardial infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Coronary thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4201  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |  |  |
| 22a. I certify that (s) (this hospital) attended the deceased from 2/17/1968, to 2/20/1968, that (s) (we) last saw the deceased alive on 2/20/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>Reynaldo Orjuela-Gomez, M.D.   |  | 22c. DATE SIGNED<br>February 20, 1968  |  | 22d. PHYSICIAN'S NAME (Type)<br>Reynaldo Orjuela-Gomez, M.D.  |  |   |  |  |  |  |  |
| 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204   |  |  |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, or other disposal (Specify)<br>Burial  |  | 23b. DATE<br>2/23/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Elk Run Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Elkton, Va.                                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home 1407 Eastern Ave.   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 27 1968   |  | 25b. REGISTERED DEATH<br>J. H. Jones  |  |  |  |  |  |

12220

UNITED STATES DEPARTMENT OF JUSTICE

0333

TO THE HONORABLE ATTORNEY GENERAL  
WASHINGTON, D. C.  
FROM THE  
[Illegible Name]  
[Illegible Address]  
[Illegible City, State, Zip]  
[Illegible Date]  
[Illegible Subject]

[Illegible body text - multiple paragraphs of a letter]

Very truly yours,  
[Illegible Signature]  
[Illegible Title]  
[Illegible Address]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle   |  | Last   |  | 2a. DATE OF DEATH                            |  |
| BERTHA  |  |  |  |  |  | LEVI   |  | FEB Month Day Year 13 1968 10A M             |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)  |  | 7. IF UNDER 1 YEAR MONTHS DAYS               |  |
| F   |  | WHITE  |  | 12-28-1888   |  | 79 YRS.  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| GERMANY   |  | USA  |  |  |  | BALTIMORE Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
|   |  | 3111 SMITH AVE   |  | CLERK  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| MD  |  | BALTO  |  |  |  |  |  | 3111 SMITH AVE                               |  |
| 14. FATHER'S NAME   |  | First  |  | Middle   |  | Last   |  | 15. MOTHER'S MAIDEN NAME                     |  |
| SOLomon   |  |  |  |  |  |  |  | NANNI  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |  |  |
| NO  |  | 216-34-4149  |  | RUTH GOLDSCHMIDT   |  | 3111 SMITH AVE   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Stroke Adam (Karl Bloch)  |  |  |  |  |  |  |  | 3 yr   |  |
| 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis C.I.D.  |  |  |  |  |  |  |  | 70 yr  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |
| 4330 Diabetes, hypoglycemia left by   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |
|   |  | Pneumonia 2/1/68   |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town                                 |  |
|   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1937, 19, to 2/13, 1968, that (I) (we) last saw the deceased alive on Feb 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  | 22c. DATE SIGNED                             |  |
| Joseph B Gross  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  |  |  |  |
| Joseph B Gross  |  |  |  |  |  |  |  |  |  |
| 22e. ADDRESS  |  | 22f. ADDRESS   |  |  |  |  |  |  |  |
| 6941 Park Heights   |  | Baltimore Md   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)   |  | (County) (State)                             |  |
| Burial  |  | 2/14/1968  |  | Chesapeake Chapel  |  | Rosedale   |  | Md   |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| Sybil S. Lewis & Son, Inc   |  | Garrison   |  | DATE FEB 15 1968   |  | Charles Judge  |  |  |  |

05325

RECORD OF DEATH

05325

1968 12 15

1968 12 15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 154  
30M REV. 1/68

| 02255   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |  |  |  |  | 02243                  |  |  |  |  |                  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|------------------------|--|--|--|--|------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |   |  |  |  |  | 2b. HOUR               |  |  |  |  |                  |  |  |  |  |
| GERTRUDE COPLAN LEVIN   |  |  |  |  |  |  |  |  |  | FEBRUARY 13, 1968  |  |  |  |  |   |  |  |  |  | 7:30 P.M.              |  |  |  |  |                  |  |  |  |  |
| 3. SEX  |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)   |  |  |  |  | IF UNDER 1 YEAR        |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |
| FEMALE  |  |  |  |  | WHITE  |  |  |  |  | AUGUST 14, 1894  |  |  |  |  | 73 YRS.   |  |  |  |  | MONTHS                 |  |  |  |  | DAYS             |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| BALTIMORE, KMD  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | BALTIMORE Md.   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
|   |  |  |  |  | PROFESSIONAL HOUSE   |  |  |  |  | HOUSEWIFE  |  |  |  |  | AT HOME   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER |  |  |  |  |                  |  |  |  |  |
| MARYLAND  |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  |  | 3600 LABYRINTH RD.     |  |  |  |  |                  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| LOUIS ELI COPLAN  |  |  |  |  | JENNIE ZELDA   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT Address  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| NO  |  |  |  |  |  |  |  |  |  | MR. ROBERT C. LEVIN, 8205 MARCIE DR. #21208  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                      |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| IMMEDIATE CAUSE (a) cerebral hemorrhage   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 3 days  |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 1941  |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| (b) Myocardial infarction   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 1962  |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| (c) Diabetes mellitus   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 331X  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 1944, to FEB. 15, 1968, that (I) (we) last saw the deceased alive on FEB. 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED  |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| DR. SAMUEL WHITEHOUSE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 2/16/68   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| DR. SAMUEL WHITEHOUSE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 3900 N. CHARLES STREET  |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| BURIAL  |  |  |  |  | 2-16-68  |  |  |  |  | Mikro Kodesh Beth Israel   |  |  |  |  | BALTIMORE, MARYLAND   |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD  |  |  |  |  |  |  |  |  |  | DATE FEB 20 1968   |  |  |  |  | f Charles J. Jones  |  |  |  |  |                        |  |  |  |  |                  |  |  |  |  |

02222

02222

02222

02222

02222



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02256  |  |   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  | 02244   |  |                                      |  |   |  |
|--|--|---|--|---|--|---|--|---|--|--------------------------------------|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |   |  | First Middle Last   |  |   |  | 2a. DATE OF DEATH<br>Month Day Year                                     |  |                                      |  | 2b. HOUR  |  |
| Alice Black Lewis  |  |   |  |   |  |   |  | February 18, 1968   |  |                                      |  | 3:15 P. M.                                      |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  |   |  | 6. AGE (In years<br>last birthday)                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS       |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| F  |  | W   |  | 4/16/1907   |  |   |  | 60 YRS.   |  |                                      |  |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |   |  |                                      |  | Md.   |  |
| Balto., Md.  |  | U.S.A.  |  |   |  | Baltimore   |  |   |  |                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)      |  |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |   |  |
| Towson   |  | Hampton House Apt.  |  |   |  | Homemaker   |  |   |  | Own Home                             |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |  |                                      |  |   |  |
| Md.  |  | Balto.  |  | Towson  |  |   |  | 316 Hampton House   |  |                                      |  |   |  |
| 14. FATHER'S NAME<br>First Middle Last   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last   |  |   |  |   |  |                                      |  |   |  |
| Duncan Black   |  |   |  | Anna Ridgely  |  |   |  |   |  |                                      |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT   |  |   |  | Address   |  |                                      |  |   |  |
| No   |  | 220-44-1489   |  | Fielding H. Lewis, Jr.,   |  |   |  | 7303 Yorktown Drive   |  |                                      |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>207.9 IMMEDIATE CAUSE (a) Leukemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |   |  |   |  |   |  |   |  |                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |   |  |   |  |                                      |  |   |  |
| 2044   |  |   |  |   |  |   |  |   |  |                                      |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                      |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |                                      |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |   |  |                                      |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1968, to Feb 18, 1968, that (I) (we) last<br>saw the deceased alive on Feb 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |                                      |  |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED  |  |   |  |   |  |   |  |                                      |  |   |  |
| Dr. Laurence C. Post M.D.  |  | 2/19/68   |  |   |  |   |  |   |  |                                      |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  | 22e. ADDRESS  |  |   |  |   |  |   |  |                                      |  |   |  |
| Dr. Laurence C. Post   |  | 6805 York Road  |  |   |  |   |  |   |  |                                      |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |   |  |                                      |  |   |  |
| Burial   |  | 2/20/68   |  | Druid Ridge   |  | Pikesville, Balto. Co. Md.  |  |   |  |                                      |  |   |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR   |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |                                      |  |   |  |
| H.W. Jenkins & Sons Co.  |  | 4905 York Rd.<br>Balto., Md.  |  |   |  | FEB 19 1968   |  | Charles Judge   |  |                                      |  |   |  |

02526

02526

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|  |                         |  |   |  |  |
|--|-------------------------|--|---|--|--|
| 02257  |                         | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                |   | 02245  |  |
| Item #23b <b>CERTIFICATE OF DEATH</b>  |                         |  |   |  |  |
| 1. DECEASED-NAME (Type or print) <b>Lola E. Lewis</b>  |                         |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>6</b> Year <b>68</b>   |  | 2b. HOUR <b>6 A M</b>                                  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>July 3, 1898</b>  |   | 6. AGE (In years last birthday) <b>69</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.             |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>5901 Edmondson Ave.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>BALTO</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>5901 Edmondson Avenue</b> |
| 14. FATHER'S NAME First Middle Last<br><b>Adekert Hooper</b>   |                         |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Martha V. Parks</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>no</b>  |                         | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Martha L. Glass, 5950 Wilson Boulevard, Arlington, Va. 22205</b>         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma metastasis</b><br><b>174X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 months</b> |                         |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>170X</b>  |                         |  |   |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                         |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>67</b> , to <b>Feb 6</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Feb 6</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                         |  |   |  |  |
| 22b. SIGNATURE<br><b>L.A. Lally M.D.</b>   |                         | DEGREE <b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>February 7, 1968</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>L.A. LALLY M.D.</b>   |                         | 22e. ADDRESS<br><b>ROLLING Rd - FREDERICKS AVE</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23b. DATE<br><b>2/8/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>                            |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>   |                         |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Witzke Funeral Directors, Balto., Md. 21229</b>   |                         | ADDRESS<br><b>4101 Edmondson Avenue</b>  |   | 25a. REC'D BY REGISTRAR<br><b>FED 8 1968</b>   |  |
|  |                         |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

0222

0224

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

John H. Davis

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |   |  |
| 1. DECEASED-NAME (Type or Print) <b>MARTHA LANE LILLY</b>  |  |  |  |   |  | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month <b>Feb</b> Day <b>26</b> Year <b>1968</b> |  | 2b. HOUR <b>5A</b> M   |  |   |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>Can</b>   |  | 5. DATE OF BIRTH <b>Mar 20, 1896</b>  |  | 6. AGE (In years last birthday) <b>81</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH <b>White Hall</b>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Central Ave</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>                                     |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>STATE W. Va.</b>  |  |  |  | 13b. COUNTY <b>W. Va.</b>   |  |  |  | 13c. CITY OR TOWN <b>Crook Orchard</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First <b>James</b> Middle <b>Snuffer</b> Lost  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>?</b> Middle <b>?</b> Lost   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  |   |  | 16b. SOCIAL SECURITY NO. <b>—</b>  |  | 17. INFORMANT <b>Family</b> ADDRESS <b>White Hall</b> <b>Md</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive Heart Disease</b><br><b>402X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |  |  |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>443X</b>   |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>                             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town   |  | County State  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>A.M. France</b>  |  |  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | 22b. DATE SIGNED <b>2/26/68</b>  |  |   |  |
| EXAMINER'S NAME (Type) <b>A.M. FRANCE</b>  |  |  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| ADDRESS (Street, city, town, or county) <b>PARKTON, B. STATE, MD</b>   |  |  |  |   |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  | 23b. DATE <b>2/29/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Calfee</b>   |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Mt. Taber. Md</b>                |  |
| 24. FUNERAL DIRECTOR <b>Wm Cook Brooks Towson</b> ADDRESS <b>4050 York</b>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR <b>FEB 29 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |   |  |

Removed to Calfee  
Funeral Home,  
Berkley  
W. Va.

VR A15ME (5)  
FORM REV. 1/68

02330

02330

Upholstery that has been

C. M. France  
P. M. FRANCE

FEB 28 1985



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)  
30M REV. 1/68

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 02259  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 02246   |  |
| 1. DECEASED-NAME<br>(Type or print) <i>SUSIE</i> First <i>BOUGHTON</i> Middle <i>LITTLEPAGE</i> Last   |  | 2a. DATE OF DEATH<br>Month <i>FEB</i> Day <i>4</i> Year <i>68</i>  |  |   |  | 2b. HOUR<br><i>10:30</i> A.M.   |  |
| 3. SEX<br><i>FEMALE</i>  |  | 4. RACE<br><i>CAUCASIAN</i>  |  | 5. DATE OF BIRTH<br><i>OCT. 25, 1888</i>  |  | 6. AGE (In years last birthday)<br><i>85</i> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>VIRGINIA</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Balto.</i>   |  |
| 10. CITY OR TOWN OF DEATH<br><i>CATONSVILLE, MD</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>SHAWNEE-LA N.H.</i>             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>HOUSEWIFE</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>   |  | 13b. COUNTY<br><i>BALTO.</i>   |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>                              |  |
| 14. FATHER'S NAME First <i>UNKNOWN</i> Middle <i>Boughton</i> Last <i>UNKNOWN</i>  |  | 15. MOTHER'S MAIDEN NAME First <i>UNKNOWN</i> Middle <i>UNKNOWN</i> Last <i>UNKNOWN</i>                            |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)   |  |   |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><i>Mr. Arthur Littlepage.</i>   |  |   |  | 22. Monclair Drive  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><i>437.9</i> IMMEDIATE CAUSE (a) <i>Antemortem - General - cerebral - cardiac</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>334X Chronic rheumatoid arthritis</i>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><i>Jan 14, 68</i>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Removal of leg</i>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 30, 1968</i> , to <i>Feb 7, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 30, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Walter B. Buck</i>  |  | 22c. DATE SIGNED<br><i>2/7/68</i>  |  | 22d. PHYSICIAN'S NAME (Type) <i>WALTER B. BUCK</i>  |  |   |  |
| 22e. ADDRESS<br><i>18 E. EAGER ST, BALTO 21202</i>   |  | 22f. DEGREE<br><i>MD</i>   |  |   |  | 22g. ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>2-10-68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Loudon Park Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Balto. Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br><i>Witzke F. D., Balto., Md. 21229</i>   |  | 24a. ADDRESS<br><i>4101 Edmondson Avenue</i>   |  | 25a. REC'D BY REGISTRAR<br><i>FEB 8 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |

03321

RECEIVED

03321

212 P. 10/10/10

10/10/10

10/10/10

10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02260   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  | 02248  |  |                                   |  |   |  |          |  |
|---|--|--|--|---|--|---|--|--|--|-----------------------------------|--|---|--|----------|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  | First   |  | Middle  |  | Last   |  | 2a. DATE OF DEATH                 |  |   |  | 2b. HOUR |  |
| James   |  |  |  | C   |  | Logan   |  | Month 2 Day 5 Year 68  |  |                                   |  | 9:54 M  |  |          |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS.                                |  |          |  |
| Male  |  | White  |  | April 18, 1899  |  |   |  | 68 YRS.  |  | MONTHS DAYS                       |  | HOURS MIN                                       |  |          |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |                                   |  | Md.   |  |          |  |
| Catochville   |  | U.S.   |  |   |  | BALTIMORE   |  |  |  |                                   |  |   |  |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |   |  |          |  |
| Catochville   |  | Summit Nursing Home, Inc.  |  |   |  | Retired Bethlehem Steel   |  |  |  |                                   |  |   |  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER   |  |                                   |  |   |  |          |  |
| Md.   |  | Anne Arundel   |  | Glen Burnie   |  |   |  | 710 Broadview Blvd   |  |                                   |  |   |  |          |  |
| 14. FATHER'S NAME   |  | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME   |  | First                             |  | Middle  |  | Last     |  |
| Frank   |  |  |  | Logan   |  |   |  | Minnie   |  |                                   |  | (UNKNOWN)                                       |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  |   |  | Address  |  |                                   |  |   |  |          |  |
| no  |  | 213-07-0114  |  | Theal M. Logan - Same as # 13a  |  |   |  |  |  |                                   |  |   |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA, TERMINAL</u><br><u>1621</u> DUE TO, OR AS A CONSEQUENCE OF <u>EMPHYSEMA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>DIETETOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>PULMONARY TBC.</u> |  |  |  |   |  |   |  |  |  |                                   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>1621</u>   |  |  |  |   |  |   |  |  |  |                                   |  |   |  |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                   |  |   |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |  |                                   |  |   |  |          |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |  |                                   |  |   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 11</u> , 19 <u>68</u> , to <u>FEB 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>FEB 2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |                                   |  |   |  |          |  |
| 22b. SIGNATURE <u>E. KASATIS, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |   |  |   |  |  |  |                                   |  | 22c. DATE SIGNED <u>FEB 5, 1968</u>             |  |          |  |
| 22d. PHYSICIAN'S NAME (Type) <u>E. KASATIS, M.D.</u>  |  |  |  |   |  |   |  |  |  |                                   |  | 22e. ADDRESS <u>1801 FREDERICK RD BALTO #28</u> |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION (City or Town) (County) (State)                        |  |                                   |  |   |  |          |  |
| Burial  |  | 2/8/1968   |  | Oak Lawn Cemetery   |  |   |  | Baltimore, Maryland  |  |                                   |  |   |  |          |  |
| 24. FUNERAL DIRECTOR <u>Robert Plake</u> ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |                                   |  |   |  |          |  |
| Singleton Funeral Home/Glen Burnie, Md.   |  |  |  | DATE <u>FEB 7 1968</u>  |  | <u>Charles Judge</u>  |  |  |  |                                   |  |   |  |          |  |

453

•

59

1

2

- vii -

11:2

15-2-73

## 1. INTRODUCTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |   |  |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |   |   |  |  |  |
| 02261  |  | 02249   |  |   |   |   |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Mary OMEY E. Lowenthal   |  |   |  | 2a. DATE OF DEATH Month Day Year<br>2-23-68   |   |   | 2b. HOUR<br>3:15 PM  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>3-21-89   |   | 6. AGE (In years lost birthday)<br>78 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Garrison  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Foxleigh Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>HOUSEWIFE  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>md  |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>Baltimore  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>3106 Northbrook Rd. 21208        |  |
| 14. FATHER'S NAME First Middle Last<br>George Morris   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Annie Felger  |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br>220 24 2310A  |  | 17. INFORMANT<br>MR. HARRY Lowenthal  |   | Address<br>3106 Northbrook Rd.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>4369 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>unknown</u> |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Minutes    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>331X   |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 22, 1968, to Feb 23, 1968, that (I) (we) last saw the deceased alive on Feb 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                      |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br>David P. Miller  |  |   |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |   | 22c. DATE SIGNED<br>2-23-68   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>David P. Miller  |  |   |  | 22e. ADDRESS<br>Lisbon Rd. - Annapolis, Md.   |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>2-25-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>HEBREW FRIENDSHIP   |   | 23d. LOCATION (City or Town) (County) (State)<br>BALTIMORE, MARYLAND                            |  |  |  |
| 24. FUNERAL DIRECTOR<br>Sol Levison  |  |   |  | ADDRESS<br>6010 REISTERSTOWN ROAD   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 26 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. J...              |  |

02380

02380

UNITED STATES OF AMERICA

*[Faint, mostly illegible text, possibly a form or document, with some visible words like "UNITED STATES OF AMERICA" and "DEPARTMENT OF JUSTICE"]*

*[Faint vertical text on the right margin, possibly a reference or filing number]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02262   |  |  |  |  |  |  |  |  |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |                          |  |  |                  |  |  |        |  | 02258 |       |  |  |          |  |  |       |  |  |    |  |  |
|---|--|--|--|--|--|--|--|--|---|---|--|--------------------------|--|--|------------------|--|--|--------|--|-------|-------|--|--|----------|--|--|-------|--|--|----|--|--|
| Item 6 Film G398 2/28/68 kk   |  |  |  |  |  |  |  |  |   | CERTIFICATE OF DEATH  |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  |  |  | Middle   |  |  | Last  |   |  | 2a. DATE OF DEATH        |  |  | Month            |  |  | Day    |  |       | Year  |  |  | 2b. HOUR |  |  | 10-15 |  |  | AM |  |  |
| Mary  |  |  | Ellen  |  |  | Lowry  |  |  |   |   |  | Feb                      |  |  | 17               |  |  | 1968   |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 3. SEX  |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)   |   |  | IF UNDER 1 YEAR          |  |  | IF UNDER 24 HRS. |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| Female  |  |  | White  |  |  | 3-23-1889  |  |  | 88 78 YRS.  |   |  | MONTHS                   |  |  | DAYS             |  |  | HOURS  |  |       | MIN.  |  |  |          |  |  |       |  |  |    |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH  |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| Frederick, Md.  |  |  | U.S.A.   |  |  |  |  |  | Baltimore   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| Lutherville   |  |  | College Manor Nursing Home   |  |  | House wife   |  |  |   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  | 13e. STREET AND NUMBER   |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| Md.   |  |  | Baltimore  |  |  | BALTO  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |   |  | 5103 Edmonson Ave        |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 14. FATHER'S NAME   |  |  | First  |  |  | Middle   |  |  | Last  |   |  | 15. MOTHER'S MAIDEN NAME |  |  | First            |  |  | Middle |  |       | Last  |  |  |          |  |  |       |  |  |    |  |  |
| John William Rine   |  |  |  |  |  |  |  |  |   |   |  | Catherine                |  |  |                  |  |  |        |  |       | Lease |  |  |          |  |  |       |  |  |    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  |  | Address   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| No  |  |  | 213-50-6979  |  |  | Nursing Home Records   |  |  |   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>myocardial infarction</u>   |  |  |  |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>                 |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>  |  |  |  |  |  |  |  |  |   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>Feb 17</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>4/17</u> , 19 <u>68</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death. |  |  |  |  |  |  |  |  |   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 22b. SIGNATURE  |  |  | 22c. DATE SIGNED   |  |  | 22d. PHYSICIAN'S NAME (Type)   |  |  | 22e. ADDRESS  |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| William J. Furr MD  |  |  | 2/17/68  |  |  |  |  |  |   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)                                     |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| Burial  |  |  | 2/20/68  |  |  | Loudon Park Cemetery   |  |  | Baltimore, Md.  |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| 24. FUNERAL DIRECTOR  |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |
| Wm. F. Tichner & Sons   |  |  | Baltimore, Md.   |  |  | FEB 20 1968  |  |  | J. F. Jones   |   |  |                          |  |  |                  |  |  |        |  |       |       |  |  |          |  |  |       |  |  |    |  |  |

117539

7-0

100

1

1991.10.20

1

• • •

2010

1517-1531

1990-1991

1955

24

**Figure 1**

1995-1996

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

C.

12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |                                   |                                |  |  |
|---|--|--|--|--|--|---|--|--|-----------------------------------|--------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR                          |                                |  |  |
| Mary L Lynch  |  |  |  |  |  | Month 2 Day 3 Year 68   |  |  | 6:50 AM                           |                                |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS       |                                | IF UNDER 24 HRS. HOURS MIN.                  |  |
| F   |  | W  |  | 12/22 1879   |  |   | 88 YRS.  |  |                                   |                                |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                                   |                                |  |  |
| Baltimore, Md   |  | USA  |  |  |  | Baltimore Md.   |  |  |                                   |                                |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |                                |  |  |
| Towson  |  |  | Stella Maris Hospice   |  |  | Clerical  |  |  |                                   |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |                                |  |  |
| Md  |  |  |  |  | Baltimore  |   |  |  | 3029 Kenyon Ave.,                 |                                |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |   |  |  |                                   |                                |  |  |
| Daniel Lynch  |  |  |  | Marie O'Donnell  |  |   |  |  |                                   |                                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   |  | Address  |                                   |                                |  |  |
| No  |  |  | 211-22-21484   |  | Hospice records  |   |  |  |                                   |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |  |                                   |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>  |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD.</u>  |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypercholesterolemia</u>  |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| 4201  |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                   |                                |  |  |
|   |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |   |  |  |                                   |                                |  |  |
|   |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |                                   |                                |  |  |
|   |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/11/62</u> , 19 <u>  </u> , to <u>2/3/68</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>2/2/68</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |                                   |                                |  |  |
| 22b. SIGNATURE <u>Robert J. Mahon</u>   |  |  |  |  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED <u>2/3/68</u> |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Robert J. Mahon, M.D.</u>   |  |  |  |  |  |   |  | 22e. ADDRESS <u>2-4 E. Joppa Rd., Towson</u>   |                                   |                                |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                                   |                                |  |  |
| BURIAL  |  | 2/6/68   |  | St. Marys Cem.   |  | Govans  |  |  |                                   |                                |  |  |
| 24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home-6500 York Rd-21212</u>  |  |  |  |  |  | 25a. RECEIVED BY REGISTRAR <u>FEB 8 1968</u> DATE                                       |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |                                   |                                |  |  |

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| <div>02264</div> <div> <div>02252</div> <div>02252</div> </div>  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |                                  |  |
|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--------------------------------|----------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>MARY  |  |  | Middle<br>ANN  |  |  | Last<br>MAC GREGOR  |  |  | 2a. DATE OF DEATH<br>Month 2 Day 4 Year 68         |  |                                | 2b. HOUR<br>5 A. M               |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>White   |  |  | 5. DATE OF BIRTH<br>2-22-1900  |  |  | 6. AGE (In years<br>last birthday)<br>67 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  | IF UNDER 24 HRS.<br>HOURS MIN. |                                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Swansea, S. Wales  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>British  |  |  | 8. MARRIED<br>NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |                                |                                  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Greater Balto Med. Center |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)                                 |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |  |                                |                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.  |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Baltimore   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>501 Hollen Rd. 21212     |  |                                |                                  |  |
| 14. FATHER'S NAME<br>Richard Thomas  |  |  | First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>Mary Llewelyn  |  |  | First Middle Last   |  |  |  |  |                                |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>212-03-4122B   |  |  | 17. INFORMANT<br>Leslie Mac Gregor, 501 Hollen Rd. 21212   |  |  | Address   |  |  |  |  |                                |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pancreatitis</u><br>5770<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |  |  |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |                                |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>5870  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |                                  |  |
| 19a. DATE OF OPERATION<br>1/30/68  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Cholecystitis  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br>yes                  |  |  |  |  |                                |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.)  |  |  |   |  |  |  |  |                                |                                  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                              |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |  |  |  |                                |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/14, 1968, to 2/4, 1968, that (I) (we) last<br>saw the deceased alive on 2/4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |                                  |  |
| 22b. SIGNATURE<br>John E. Adams  |  |  | DEGREE   |  |  | ATTENDING<br>PHYS. <input type="checkbox"/>  |  |  | MED.<br>DIRECTOR <input type="checkbox"/>   |  |  | STAFF<br>PHYS. <input checked="" type="checkbox"/> |  |                                | 22c. DATE SIGNED<br>Feb. 4, 1968 |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>John E. Adams, M.D.   |  |  | 22e. ADDRESS<br>6701 N. Charles St. Towson, Md.  |  |  |  |  |  |   |  |  |  |  |                                |                                  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  |  | 23b. DATE<br>2-10-1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Tabor Chapel,  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Swansea, South Wales, (G.B.)                   |  |  |  |  |                                |                                  |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, 1050 York Rd.  |  |  | ADDRESS<br>T n Md. 21204   |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 9 1968   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |                                |                                  |  |

0230

0230

0230

0230

0230

(...)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |   |   |   |  |
|--|--|--|--|---|---|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |   |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |   |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First MARY Middle MARCAVAGE Last   |   |   | 2a. DATE OF DEATH<br>Month FEB. Day 18, Year 68   |   | 2b. HOUR<br>4:45 M  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>9-13-82   |   | 6. AGE (In years<br>last birthday)<br>85 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>LITHUANA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>HALETHORPE  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>4510 MAPLE AVENUE |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOMEMAKER   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE MD.   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>HALETHORPE   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>               |   | 13e. STREET AND NUMBER<br>4510 MAPLE AVE. 21227                 |  |
| 14. FATHER'S NAME<br>First PETER Middle RAULINAITIS Last   |  |  | 15. MOTHER'S MAIDEN NAME<br>First GERTRUDE Middle KURMONAVAGE Last GREEN |   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) NO (If yes give war or dates of service) |   |   |  |
| 16b. SOCIAL SECURITY NO.<br>213508011  |  | 17. INFORMANT<br>ANASTASIA GREEN Address 4510 MAPLE AVE. 21227                                       |  |   |   |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic CVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>?</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>sudden</u><br><u>? yrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4221</u>  |  |  |  |   |   |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                   |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>65</u> , to <u>2/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                       |  |  |  |   |   |   |   |   |  |
| 22b. SIGNATURE<br><u>Herbert J. Levickas, MD</u>   |  |  |  |   |   | 22c. DATE SIGNED<br><u>2/18/68</u>  |   |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>HERBERT J. LEVICKAS   |  | 22e. ADDRESS<br>5404 EAST DR. 21227  |  |   |   |   |   |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>2-20-68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ST. LOUIS CEMETERY  |   | 23d. LOCATION (City or Town) (County) (State)<br><del>KIRK</del> FRACKVILLE, PA.                              |   |   |  |
| 24. FUNERAL DIRECTOR<br>HOWARD H. HUBBARD 4107 WILKENS AVE. 21229  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 20 1968   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Young</u>  |   |   |  |

03330

DEPARTMENT OF DEFENSE

ARMY

NAVY

NAVY

U

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

NAVY

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RMB-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                      |  |  |  |  |  |  |   |  |
|---|----------------------|--|--|--|--|--|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |  |  |  |  |  |  |   |  |
| 02266   |                      | 02254  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (Type or Print) <b>Harold Markley</b>  |                      |  |  | 20. DATE KNOWN OF DEATH <b>2 14 19 68</b>  |  | 2b. HOUR <b>6:35 A</b>   |  |   |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH <b>June 4, 1907</b>   | 6. AGE (In years last birthday) <b>60 YRS.</b> | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS<br>HOURS <b></b> MIN <b></b> | 2c. DATE PRONOUNCED DEAD <b>Month 2 Day 14 Year 19 68</b>                                    |  | 2d. HOUR <b>8:00 A</b>                                      |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Baltimore W. Va.</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Sparrows Point</b>   |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Plant Dispensary</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Shipyard worker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Shipbldg.</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |                      | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>236 S. Mount St 21223</b>         |  |
| 14. FATHER'S NAME First <b>Perry</b> Middle <b>Markley</b> Last <b></b>   |                      |  |  | 15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b></b> Last <b></b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>?</b>   |                      | 16b. SOCIAL SECURITY NO. <b>?</b>  |  | 17. INFORMANT ADDRESS <b>Mrs Harold Markley - Wife - Above</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |                      |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Stat</b>    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221 N</b>   |                      |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>4 22 68</b>   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>E</b>   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH <b>N</b>  |                      | 21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b></b> P.M. <b></b>                        |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>N</b>                |  | 21f. LOCATION Street or R.F.D. No. <b>E</b>  |  | City or Town <b></b>   |  | County <b></b> State <b></b>                                |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>MB Davis</b>  |                      | EXAMINER'S NAME (Type) <b>Melvin B. Davis, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
|   |                      |  |  | ADDRESS (Street, city, town, or county) <b>6800 Mornington Rd. Baltimore, Md. 21222</b>  |  | 22b. DATE SIGNED <b>2/14/68</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                      | 23b. DATE <b>2-17-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Petersburg</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Petersburg W. Va.</b>                       |  |   |  |
| 24. FUNERAL DIRECTOR <b>Arthur H. Haight</b>  |                      | ADDRESS <b>Hydenville, Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>FEB 16 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>                                     |  |   |  |

02222

02222

DATE: 10/10/50 TIME: 10:00 AM

TO: SAC, NEW YORK FROM: SAC, ALBANY

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02267

02255

|  |  |   |  |  |  |  |   |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO.</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MO</b> b. COUNTY <b>BALTO</b>                       |  |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>  |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6 DOROTHY AVE</b>  |  |   |  | d. STREET ADDRESS <b>6 DOROTHY AVE</b>   |  |  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |   |
| 3. NAME OF DECEASED (Type or print) <b>ELIZABETH MARKS</b>   |  |   |  | 4. DATE OF DEATH <b>FEB 10 1968</b>  |  |  |   |
| 5. SEX <b>F</b>  |  | 6. COLOR OR RACE <b>W</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>6/10/12</b>                                      |   |
| 9. AGE (in years last birthday) <b>55</b> yrs.   |  | IF UNDER 1 YEAR Months Days   |  | IF UNDER 24 HRS. Hours Min.  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>BALTO. MO</b> |   |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  |  |  |  |   |
| 13. FATHER'S NAME <b>ROSINSKI</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>P</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  | 16. SOCIAL SECURITY NO. (If yes give war or dates of service)   |  | 17. INFORMANT <b>GEORGE MARKS</b>  |  | Address <b>ABOVE</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis toxemia</b><br><b>1533</b> DUE TO (b) <b>Carcinoma of Sigmoid</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b><br><b>5 yrs</b>                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1533</b>  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                 |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1966</b> to <b>2-10, 1968</b> , that (I) (we) last saw the deceased alive on <b>2/9, 1968</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.   |  |   |  |  |  |  |   |
| 22a. SIGNATURE <b>M. Barmgardner</b> M.D.  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <b>2/10/68</b>                                      |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Balto 212-37</b>   |  |   |  | 22d. ADDRESS   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE THEREOF <b>2/14/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>   |  | 23d. LOCATION (City, town or county) (State) <b>BALTO. MO</b>        |   |
| 24. FUNERAL DIRECTOR <b>J.B. CONNELLY SONS</b>   |  |   |  | ADDRESS <b>300 MACE</b>  |  | 25a. REC'D BY REGISTRAR <b>FEB 14 1968</b>                           |   |
|  |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |   |

MEDICAL CERTIFICATION

1955

1955





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 02268   |  | 02256  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First Middle Last  |  |
| JOSEPH  |  | MARSHALL   |  |
| 2a. DATE OF DEATH   |  | Month Day Year   |  |
| FEBRUARY 14 1968  |  | 9:40 AM  |  |
| 3. SEX  |  | 4. RACE  |  |
| MALE  |  | NEGRO  |  |
| 5. DATE OF BIRTH  |  | 6. AGE (In years lost birthday)  |  |
| 3/2/95  |  | 72 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |
| WASHINGTON, D. C.   |  | U.S.A.   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH   |  |
|   |  | BALTIMORE COUNTY, Md.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |
| FORT HOWARD   |  | VET. ADM. HOSPITAL   |  |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| LABORER   |  | CONSTRUCTION   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. CITY OR TOWN  |  |
| MARYLAND  |  | BALTIMORE  |  |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER   |  |
|   |  | 1214 Edison Hwy.   |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |
| First Middle Last   |  | First Middle Last  |  |
| WESLEY MARSHALL   |  | LOUISE JOHNSON   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  |
| YES WW I  |  | 218 09 40 41   |  |
| 17. INFORMANT   |  | Address  |  |
| CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |
| IMMEDIATE CAUSE (a) <u>RECENT MYOCARDIAL INFARCTION</u>   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |
| (c)   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |
| <u>CHRONIC PYELONEPHRITIS. HYPERTENSIVE CARDIOVASCULAR DISEASE</u>  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |
|   |  |  |  |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  |
|   |  | HOUR A.M. Month Day Year   |  |
|   |  | P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  | 21f. LOCATION  |  |
|   |  | Street or R.F.D. No. City or Town County State                               |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>2/13/68</u> , 19 <u>  </u> , to <u>2/14/68</u> , 19 <u>  </u> , that (X) (we) last saw the deceased alive on <u>2/14/68</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  |
| <i>Rodolfo G. Miro</i>  |  | 2/14/68  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | 22e. ADDRESS   |  |
| RODOLFO G. MIRO, M. D.  |  | VAH FORT HOWARD, MARYLAND  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  |
| BURIAL  |  | 2-19-68  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)                                |  |
| BALTIMORE NATIONAL  |  | BALTIMORE, MD.   |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  |
| <i>Ernest O. Walsen</i>   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| WILSON FUNERAL HOME   |  | <i>Charles Judge</i>   |  |
| ORLEANS STREET, BALTIMORE, MD.  |  | DATE FEB 15 1968   |  |

02220

02220

RECEIVED AT 10:00 AM

10:00 AM

10:00 AM

10

10:00

10:00

10:00

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

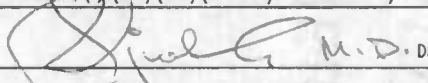

10:00 AM

10:00 AM

10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>02269</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02257</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First <b>ANNA (Annie)</b> Middle <b>MASCHERONI</b> Last <b>MASCHERONI</b>   |  |   |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>5</b> Year <b>1968</b>  |  |   |  | 2b. HOUR<br><b>7:25 PM</b>                              |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>8/17/1892</b>  |  |   |  | 6. AGE (In years<br>last birthday)<br><b>75</b> YRS.    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Italy</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>Homemaker</b>      |  |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER<br><b>1701 Ingram Rd.</b>  |  |   |  |   |  |
| 14. FATHER'S NAME First <b>?</b> Middle <b>?</b> Last <b>Merenda</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Unknown</b> Last <b>Unknown</b>   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>218-07-6668</b>  |  | 17. INFORMANT Address<br><b>Mr. Alfred Maskeroni, 1717 Ingram Rd. 21214</b>   |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary thrombo-embolism</b><br><b>450x</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. <b>465x</b> |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Carcinoma of stomach with metastases</b>  |  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |  |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |   |  |
| 22a. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>January 27, 1968</b> , to <b>February 5, 1968</b> , that <del>(I)</del> (we) last<br>saw the deceased alive on <b>February 5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. <del>(H)</del> (we) (did) (did not) view the body after death.      |  |   |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><br>22d. PHYSICIAN'S NAME (Type) <b>Reynaldo Orjuela-Gomez, M.D.</b>   |  |   |  | 22c. DATE SIGNED<br><b>February 6, 1968</b>   |  |   |  | 22e. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b> |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/10/68.</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |  |   |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 8 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02270  |  |  |  |  |  |  |  |  |  | 02258   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--------------------------------|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH<br>Month Day Year   |  |  |  |  | 2b. HOUR   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| LENWOOD  |  |  |  |  | BLAIR MASINCUPP  |  |  |  |  | February 16, 1968   |  |  |  |  | 6:20 PM  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 3. SEX<br>male   |  |  |  |  | 4. RACE<br>White   |  |  |  |  | 5. DATE OF BIRTH<br>8/12/1908   |  |  |  |  | 6. AGE (in years<br>last birthday)<br>59 YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                    |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>VIRGINIA   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore County, Md.  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Mount Wilson  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Mt. Wilson State Hospital                           |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Surveyor  |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Balto. Co.   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MD.  |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  | 13c. CITY OR TOWN<br>Dundalk  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>3006 Solters Point Rd., |  |  |  |  |                                |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Tuckin Masincupp   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Nannie Rohrer   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <input checked="" type="checkbox"/> No   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>213-09-1762   |  |  |  |  | 17. INFORMANT<br>Address<br>Records, Mt. Wilson State Hospital  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Ca of the lung. (out cell).</u><br><u>1621</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |  |  |  |  |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>1621 Pulmonary Tuberculosis</u>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                                    |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/16/</u> , 19 <u>67</u> , to <u>2/16/</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>2/16/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 22b. SIGNATURE<br><u>W. Newcomer</u>   |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br>2/16/68   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) Wm. Newcomer, M.D.   |  |  |  |  | 22e. ADDRESS<br>Mount Wilson, Maryland   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>BURNING (Specify)   |  |  |  |  | 23b. DATE<br>2/20/68   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge Memorial Pk.  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Dorsey, Md.   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 7922 Wise Ave. Dundalk, Md.  |  |  |  |  | ADDRESS<br>Dundalk, Md.  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>FEB 19 1968  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |  |   |  |  |  |  |                                |  |  |  |  |

02220

02220

02220





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/76

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |         |   |          |  |  |   |          |  |  |
|---|--|--|--|--|---------|---|----------|--|--|---|----------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |         |   |          |  |  |   |          |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |         |   |          |  |  |   |          |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  |  | Middle  |   | Last     |  | 2a. DATE OF DEATH<br>Month Day Year  |   | 2b. HOUR |  |  |
| Colette   |  |  | M.   |  | MASKELL |   |          |  | February 21, 1968  |   | 2:30PM   |  |  |
| 3. SEX  |  |  | 4. RACE  |  |         | 5. DATE OF BIRTH  |          |  | 6. AGE (In years last birthday)  |   |          | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |  |
| Female  |  |  | White  |  |         | August 24, 1900   |          |  | 67 YRS.  |   |          |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |         | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |          |  | 9. COUNTY OF DEATH   |   |          |  |  |
| Maryland  |  |  | U.S.A.   |  |         |   |          |  | Baltimore, Md.   |   |          |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |         | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |          |  |  |
| Towson  |  |  | ST. JOSEPH HOSPITAL  |  |         | Homemaker   |          |  |  |   |          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |         | 13c. CITY OR TOWN   |          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |          | 13e. STREET AND NUMBER                   |  |
| Maryland  |  |  |  |  |         | Baltimore   |          |  |  |   |          | 3109 Gibbons Ave.<br>2084 Echodale Ave.  |  |
| 14. FATHER'S NAME   |  |  | First  |  | Middle  |   | Last     |  | 15. MOTHER'S MAIDEN NAME   |   |          | First Middle Last                        |  |
|   |  |  | Kinlein  |  |         |   | Dorothea |  | Stengel  |   |          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)            |  |         | 17. INFORMANT   |          |  | Address  |   |          |  |  |
| No  |  |  | 219-50-9022  |  |         | Mr. Kenneth T. Maskell  |          |  | (Same)   |   |          |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>592X IMMEDIATE CAUSE (a) Acute pyelonephritis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Obstructive uropathy<br>rt. ureter<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Calculi in left renal pelvis & blood clot in |  |  |  |  |         |   |          |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>602X Thrombocytopenic purpura  |  |  |  |  |         |   |          |  |  |   |          |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |         | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |          |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |         | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |          |  |  |   |          |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |         | 21f. LOCATION Street or R.F.D. No. City or Town County State  |          |  |  |   |          |  |  |
|   |  |  |  |  |         |   |          |  |  |   |          |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 2/8/1968, to 2/21/1968, that (X) (we) last saw the deceased alive on 2/21/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                 |  |  |  |  |         |   |          |  |  |   |          |  |  |
| 22b. SIGNATURE<br>George D. M... DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  |  |         |   |          |  | 22c. DATE SIGNED<br>February 21, 1968  |   |          |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |         |   |          |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204   |   |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  |         | 23c. NAME OF CEMETERY OR CREMATORY  |          |  | 23d. LOCATION (City or Town) (County) (State)  |   |          |  |  |
| Entombment  |  |  | 2/24/68.   |  |         | Lorraine Mausoleum  |          |  | Baltimore, Md.   |   |          |  |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Balto. Md. 21211  |  |  |  |  |         | 25a. REC'D BY REGISTRAR<br>DATE FEB 23 1968   |          |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J...   |   |          |  |  |

7530

1

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

1. *Journal of the American Medical Association*, 1997; 277: 1033-1036.

1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078 1079 1080 1081 1082 1083 1084 1085 1086 1087 1088 1089 1090 1091 1092 1093 1094 1095 1096 1097 1098 1099 1100 1101 1102 1103 1104 1105 1106 1107 1108 1109 1110 1111 1112 1113 1114 1115 1116 1117 1118 1119 1120 1121 1122 1123 1124 1125 1126 1127 1128 1129 1130 1131 1132 1133 1134 1135 1136 1137 1138 1139 1140 1141 1142 1143 1144 1145 1146 1147 1148 1149 1150 1151 1152 1153 1154 1155 1156 1157 1158 1159 1160 1161 1162 1163 1164 1165 1166 1167 1168 1169 1170 1171 1172 1173 1174 1175 1176 1177 1178 1179 1180 1181 1182 1183 1184 1185 1186 1187 1188 1189 1190 1191 1192 1193 1194 1195 1196 1197 1198 1199 1200 1201 1202 1203 1204 1205 1206 1207 1208 1209 1210 1211 1212 1213 1214 1215 1216 1217 1218 1219 1220 1221 1222 1223 1224 1225 1226 1227 1228 1229 1230 1231 1232 1233 1234 1235 1236 1237 1238 1239 1240 1241 1242 1243 1244 1245 1246 1247 1248 1249 1250 1251 1252 1253 1254 1255 1256 1257 1258 1259 1260 1261 1262 1263 1264 1265 1266 1267 1268 1269 1270 1271 1272 1273 1274 1275 1276 1277 1278 1279 1280 1281 1282 1283 1284 1285 1286 1287 1288 1289 1290 1291 1292 1293 1294 1295 1296 1297 1298 1299 1300 1301 1302 1303 1304 1305 1306 1307 1308 1309 1310 1311 1312 1313 1314 1315 1316 1317 1318 1319 1320 1321 1322 1323 1324 1325 1326 1327 1328 1329 1330 1331 1332 1333 1334 1335 1336 1337 1338 1339 1340 1341 1342 1343 1344 1345 1346 1347 1348 1349 1350 1351 1352 1353 1354 1355 1356 1357 1358 1359 1360 1361 1362 1363 1364 1365 1366 1367 1368 1369 1370 1371 1372 1373 1374 1375 1376 1377 1378 1379 1380 1381 1382 1383 1384 1385 1386 1387 1388 1389 1390 1391 1392 1393 1394 1395 1396 1397 1398 1399 1400 1401 1402 1403 1404 1405 1406 1407 1408 1409 1410 1411 1412 1413 1414 1415 1416 1417 1418 1419 1420 1421 1422 1423 1424 1425 1426 1427 1428 1429 1430 1431 1432 1433 1434 1435 1436 1437 1438 1439 1440 1441 1442 1443 1444 1445 1446 1447 1448 1449 1450 1451 1452 1453 1454 1455 1456 1457 1458 1459 1460 1461 1462 1463 1464 1465 1466 1467 1468 1469 1470 1471 1472 1473 1474 1475 1476 1477 1478 1479 1480 1481 1482 1483 1484 1485 1486 1487 1488 1489 1490 1491 1492 1493 1494 1495 1496 1497 1498 1499 1500 1501 1502 1503 1504 1505 1506 1507 1508 1509 1510 1511 1512 1513 1514 1515 1516 1517 1518 1519 1520 1521 1522 1523 1524 1525 1526 1527 1528 1529 1530 1531 1532 1533 1534 1535 1536 1537 1538 1539 1540 1541 1542 1543 1544 1545 1546 1547 1548 1549 1550 1551 1552 1553 1554 1555 1556 1557 1558 1559 1560 1561 1562 1563 1564 1565 1566 1567 1568 1569 1570 1571 1572 1573 1574 1575 1576 1577 1578 1579 1580 1581 1582 1583 1584 1585 1586 1587 1588 1589 1590 1591 1592 1593 1594 1595 1596 1597 1598 1599 1600 1601 1602 1603 1604 1605 1606 1607 1608 1609 1610 1611 1612 1613 1614 1615 1616 1617 1618 1619 1620 1621 1622 1623 1624 1625 1626 1627 1628 1629 1630 1631 1632 1633 1634 1635 1636 1637 1638 1639 1640 1641 1642 1643 1644 1645 1646 1647 1648 1649 1650 1651 1652 1653 1654 1655 1656 1657 1658 1659 1660 1661 1662 1663 1664 1665 1666 1667 1668 1669 1670 1671 1672 1673 1674 1675 1676 1677 1678 1679 1680 1681 1682 1683 1684 1685 1686 1687 1688 1689 1690 1691 1692 1693 1694 1695 1696 1697 1698 1699 1700 1701 1702 1703 1704 1705 1706 1707 1708 1709 1710 1711 1712 1713 1714 1715 1716 1717 1718 1719 1720 1721 1722 1723 1724 1725 1726 1727 1728 1729 1730 1731 1732 1733 1734 1735 1736 1737 1738 1739 1740 1741 1742 1743 1744 1745 1746 1747 1748 1749 1750 1751 1752 1753 1754 1755 1756 1757 1758 1759 1760 1761 1762 1763 1764 1765 1766 1767 1768 1769 1770 1771 1772 1773 1774 1775 1776 1777 1778 1779 1780 1781 1782 1783 1784 1785 1786 1787 1788 1789 1790 1791 1792 1793 1794 1795 1796 1797 1798 1799 1800 1801 1802 1803 1804 1805 1806 1807 1808 1809 1810 1811 1812 1813 1814 1815 1816 1817 1818 1819 1820 1821 1822 1823

• • • • •

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040

457

1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|--------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>FRANK  |  |  | Middle<br>WILLIS  |  |  | Last<br>MATTHEWS   |  |  | 2a. DATE OF DEATH<br>2 / 18 / 1968              |  |  | 2b. HOUR<br>7:30 AM            |  |  |
| 3. SEX<br>male   |  |  | 4. RACE<br>white  |  |  | 5. DATE OF BIRTH<br>10/19/1895  |  |  | 6. AGE (in years<br>last birthday)<br>72 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Michigan   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore County Md.   |  |  |   |  |  |                                |  |  |
| 10. CITY OR TOWN OF DEATH<br>Mt. Wilson  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Mt. Wilson State Hosp. |  |  |   |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>factory worker |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY            |  |  |                                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MD.  |  |  | 13b. COUNTY<br>Carolina   |  |  | 13c. CITY OR TOWN<br>Ridgely  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |  | 13e. STREET AND NUMBER<br>101 Maple Ave.        |  |  |                                |  |  |
| 14. FATHER'S NAME<br>First<br>Leland   |  |  | Middle<br>Mathers   |  |  | Last<br>Powers  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>MARTHA  |  |  | Middle<br>Rosina                                |  |  | Last<br>Powers                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>213-01-5555                          |  |  | 17. INFORMANT<br>Address<br>Records, Mt. Wilson State Hospital  |  |  |  |  |  |   |  |  |                                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cancer of the lung</u><br>1621<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |  |   |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |                                |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>163X Pulmonary Tuberculosis  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                                      |  |  |   |  |  |                                |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |   |  |  |                                |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                           |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |   |  |  |                                |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/11/1967</u> to <u>2/18/1968</u> , that (I) (we) lost<br>saw the deceased alive on <u>2/18/1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |   |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| 22b. SIGNATURE<br><u>W Newcomer</u>  |  |  | DEGREE  |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input checked="" type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/>                    |  |  | 22c. DATE SIGNED   |  |  |   |  |  |                                |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>William Newcomer, M.D.  |  |  | 22e. ADDRESS<br>Mount Wilson, Maryland  |  |  |   |  |  |  |  |  |   |  |  |                                |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>2-21-68  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Ridgely   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Ridgely, Caroline, Md.                                      |  |  |   |  |  |                                |  |  |
| 24. FUNERAL DIRECTOR<br><u>John S. Boulis</u>  |  |  | ADDRESS<br><u>Greenboro</u>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 23 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |  |   |  |  |                                |  |  |

03330

03330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514  
30M REV. 1/68

| 1. DECEASED-NAME   |  |  |  | First   |  | Middle  |  | Last   |  | 2a. DATE OF DEATH |  |  |  | 2b. HOUR                                     |  |         |  |
|--|--|--|--|---|--|---|--|--|--|-------------------|--|--|--|--|--|---------|--|
| (Type or print)  |  |  |  |   |  |   |  |  |  | Month             |  | Day  |  | Year   |  | 7:45 AM |  |
| Cornelia   |  |  |  |   |  |   |  | MAYNOR   |  | February 13,      |  | 1968   |  |  |  |         |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |   |  | 6. AGE (In years last birthday)  |  | 7. UNDER 1 YEAR   |  | 8. UNDER 24 HRS.   |  |  |  |         |  |
| Female   |  | Negro  |  | October 18, 1894  |  |   |  | 73 RS.   |  | MONTHS            |  | DAYS   |  | HOURS  |  | MIN.    |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED   |  | 9. COUNTY OF DEATH   |  |                   |  |  |  |  |  |         |  |
| North Carolina   |  | U.S.A.   |  | WIDOWED   |  | DIVORCED  |  | Baltimore,   |  |                   |  |  |  |  |  | Md.     |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                   |  |  |  |  |  |         |  |
| Towson   |  | ST. JOSEPH HOSPITAL  |  | Homemaker   |  | Home  |  |  |  |                   |  |  |  |  |  |         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER   |  |                   |  |  |  |  |  |         |  |
| Maryland   |  |  |  | Baltimore   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 459 Schwartz Ave.  |  |                   |  |  |  |  |  |         |  |
| 14. FATHER'S NAME  |  | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME   |  | First             |  | Middle   |  | Last   |  |         |  |
| John   |  | Lewis  |  |   |  |   |  | Annie  |  |                   |  |  |  |  |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address   |  |  |  |                   |  |  |  |  |  |         |  |
| No   |  | Unknown  |  | Ethel Exum  |  | 832 Whitmore Ave. Sulte. 12   |  |  |  |                   |  |  |  |  |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |  |  |                   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |         |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| IMMEDIATE CAUSE (a) Gastro-intestinal bleeding, chronic  |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| 1539 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| (b) Intestinal tumor, probably malignant.  |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| (c)  |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| 1539   |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?  |  |                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |         |  |
|  |  |  |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                   |  |  |  |  |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                                    |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |                   |  |  |  |  |  |         |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)            |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |                   |  |  |  |  |  |         |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 1/31/1968, to 2/13/1968, that (X) (we) last saw the deceased alive on 2/13/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |  |  |                   |  |  |  |  |  |         |  |
| 22b. SIGNATURE   |  |  |  | Jaime Punzalan, M.D.  |  |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |                   |  | 22c. DATE SIGNED February 13, 1968                                   |  |  |  |         |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  | Jaime Punzalan  |  |   |  | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204  |  |                   |  |  |  |  |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  | 23b. DATE 2/16/68   |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY Carver Mem. Pk. Laurel, Md.   |  |                   |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |  |         |  |
| 24. FUNERAL DIRECTOR   |  |  |  | ADDRESS   |  |   |  | 25a. REC'D BY REGISTRAR DATE   |  |                   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |         |  |
| Wm. L. Chaturian   |  |  |  | 1701 M. C. St.  |  |   |  | FEB 19 1968  |  |                   |  | James Judge  |  |  |  |         |  |

03230

03230

03230



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |                                    |   |  |   |  |  |                        |  |
|---|--|--|--|--|------------------------------------|---|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| CERTIFICATE OF DEATH  |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  |  | Middle                             |   | Last   |   | 2a. DATE OF DEATH  |  |                        |  |
|   |  |  | Leo  |  | LeRoy                              |   | McConville   |   | Month Day Year<br>Feb. 18, 1968  |  |                        |  |
| 3. SEX  |  |  | 4. RACE  |  | 5. DATE OF BIRTH                   |   |  | 6. AGE (In years last birthday)               |  | 2b. HOUR                                     |                        |  |
| Male  |  |  | White  |  | Dec. 10, 1900                      |   |  | 67 YRS.                                       |  | 7P. M.                                       |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. COUNTY OF DEATH   |  |                        |  |
| Baltio., Md.  |  |  | U.S.A.   |  |                                    |   |  |   | Baltimore Md.  |  |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |
| Reisterstown  |  |  | 101 Brunk Rd., Reisterstown  |  |                                    | Russian   |  |   | Russian Union  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN   |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Md.   |  |  | Baltimore  |  |                                    | Reisterstown  |  |   |  |  | 101 Brunk Rd.          |  |
| 14. FATHER'S NAME   |  |  | First  |  | Middle                             |   | Last   |   | 15. MOTHER'S MAIDEN NAME   |  |                        |  |
|   |  |  |  |  | Unknown                            |   |  |   | Unknown  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or unknown) (If yes, give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT   |  |   | Address  |  |                        |  |
| None  |  |  | ) 084-14-3420  |  |                                    | Mrs. Evelyn A. McConville   |  |   | 101 Brunk Rd.  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                                    |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| IMMEDIATE CAUSE (a) Cerebral vascular accident  |  |  |  |  |                                    |   |  |   |  | 2 days                                       |                        |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease  |  |  |  |  |                                    |   |  |   |  | years  |                        |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| 4221  |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |
|   |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                        |  |
|   |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |                        |  |
|   |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July 6, 1965, to Feb. 18, 1968, that (I) (we) last saw the deceased alive on Feb. 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                    |   |  |   |  |  |                        |  |
| 22b. SIGNATURE  |  |  |  |  |                                    |   |  |   | 22c. DATE SIGNED   |  |                        |  |
| Martin E. Strobel   |  |  |  |  |                                    |   |  |   | 2-20-68  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |                                    | 22e. ADDRESS  |  |   |  |  |                        |  |
| Martin E. Strobel, M.D.   |  |  |  |  |                                    | 59 Hanover Rd. Reisterstown, Md.  |  |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |  | 23d. LOCATION (City or Town) (County) (State) |  |  |                        |  |
| ENTOMBMENT  |  |  | Feb. 20, 1968  |  | Western Cemetery                   |   |  | Baltimore Md.                                 |  |  |                        |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |                                    | ADDRESS   |  | 25a. REC'D BY REGISTRAR                       |  | 25b. REGISTRAR'S SIGNATURE                   |                        |  |
| Frank H. Newell   |  |  |  |  |                                    | Pikesville, Md.   |  | FEB 21 1968                                   |  |  |                        |  |

7330

255-1000

707

7. 2. 3. 20

20

57

000 000 000

4. 2. 2.

• • •

1955

Figure 1

1997

• • • • •

70

0.2550

1

$\frac{1}{\sqrt{\pi}} \int_{-\infty}^{\infty} f(x) \delta(x-a) dx = f(a)$

R.E. Ewing et al.

• 5 •

51-12

666

90-11-18-000

1000

1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>02275</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02263</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>   |  |  |   |  |                                    |   |      |   |  |                            |   |  |                                    |  |
|---|--|--|---|--|------------------------------------|---|------|---|--|----------------------------|---|--|------------------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First   |  | Middle                             |   | Last |   | 2a. DATE OF DEATH  |                            | 2b. HOUR  |  |                                    |  |
| Thomas  |  |  | T.  |  | McCORMICK                          |   |      |   | Month 2 Day 20 Year 68   |                            | 6:50 <sup>AM</sup>  |  |                                    |  |
| 3. SEX  |  |  | 4. RACE   |  |                                    | 5. DATE OF BIRTH  |      |   | 6. AGE (In years last birthday)                                      |                            | IF UNDER 1 YEAR<br>MONTHS DAYS  |  |                                    |  |
| Male  |  |  | White   |  |                                    | 1/11/08   |      |   | 60 YRS.  |                            | IF UNDER 24 HRS.<br>HOURS MIN   |  |                                    |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   | 9. COUNTY OF DEATH   |                            |   |  |                                    |  |
| Maryland  |  |  | U.S.A.  |  |                                    |   |      |   | Baltimore Md.  |                            |   |  |                                    |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)    |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |      |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |                            |   |  |                                    |  |
| Owings Mills  |  |  | Rosewood State Hospital   |  |                                    | Farmand   |      |   | none   |                            |   |  |                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY   |  |                                    | 13c. CITY OR TOWN   |      |   | 13d. INSIDE CITY LIMITS?   |                            | 13e. STREET AND NUMBER  |  |                                    |  |
| Maryland  |  |  | Allegheny   |  |                                    | Lonaconing  |      |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                            | 134 Frederick Street  |  |                                    |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |                                    |   |      |   |  |                            |   |  |                                    |  |
| First Middle Last   |  |  | First Middle Last   |  |                                    |   |      |   |  |                            |   |  |                                    |  |
| David   |  |  | Ralston   |  |                                    | Isabelle  |      |   | McCormick  |                            |   |  |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.  |  |                                    | 17. INFORMANT   |      |   | Address  |                            |   |  |                                    |  |
| no  |  |  | #214-36-8434  |  |                                    | Rosewood Records, Owings Mills, Maryland  |      |   |  |                            |   |  |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, Acute</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Arterio-sclerosis, Generalized</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>4109</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> |  |  |   |  |                                    |   |      |   |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Few Minutes</u><br><br><u>8 years</u>  |  |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Congenital Moron, Etiology Not Determined</u>  |  |  |   |  |                                    |   |      |   |  |                            |   |  |                                    |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |                                    | 20a. AUTOPSY?   |      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                            |   |  |                                    |  |
|   |  |  |   |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |      |   |  |                            |   |  |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |   |  |                            |   |  |                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |      |   |  |                            |   |  |                                    |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>5/8</u> , 19 <u>24</u> , to <u>2/20</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>2/20</u> , 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.  |  |  |   |  |                                    |   |      |   |  |                            |   |  |                                    |  |
| 22b. SIGNATURE<br><u>Harry G. Butler M.D.</u>   |  |  |   |  |                                    |   |      |   | DEGREE   |                            | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><u>2/21/68</u> |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Harry G. Butler, M.D.</u>  |  |  |   |  |                                    |   |      |   | 22e. ADDRESS<br><u>Rosewood St. Hospl, Owings Mills, Md.</u>         |                            |   |  |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |   |      | 23d. LOCATION (City or Town) (County) (State) |  |                            |   |  |                                    |  |
| <u>Burial</u>   |  |  | <u>Feb. 26, 68</u>  |  | <u>Rosewood Cemetery</u>           |   |      | <u>Owings Mills, Md.</u>                      |  |                            |   |  |                                    |  |
| 24. FUNERAL DIRECTOR  |  |  |   |  |                                    | ADDRESS   |      | 25a. REC'D BY REGISTRAR                       |  | 25b. REGISTRAR'S SIGNATURE |   |  |                                    |  |
| <u>J. F. Eline &amp; Sons Reisterstown, Md.</u>   |  |  |   |  |                                    |   |      | <u>FEB 28 1968</u>                            |  | <u>Charles Judge</u>       |   |  |                                    |  |

02224

UNITED STATES OF AMERICA

02224

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> <span>02276</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02264</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>1. DECEASED NAME (Type or print)</span> <span>First Middle Last</span> <span>2a. DATE OF DEATH</span> <span>2b. HOUR</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>(LOUIE) T. McDADE</span> <span>February 9 1968</span> <span>9:50pm</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>3. SEX</span> <span>4. RACE</span> <span>5. DATE OF BIRTH</span> <span>6. AGE (In years last birthday)</span> <span>IF UNDER 1 YEAR</span> <span>IF UNDER 24 HRS.</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Male</span> <span>White</span> <span>December 28, 1920</span> <span>47 YRS.</span> <span>MONTHS</span> <span>DAYS</span> <span>HOURS</span> <span>MIN</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>7a. BIRTHPLACE (State or foreign country)</span> <span>7b. CITIZEN OF WHAT COUNTRY?</span> <span>8. MARRIED</span> <span>NEVER MARRIED</span> <span>9. COUNTY OF DEATH</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Maryland</span> <span>U.S.</span> <span>WIDOWED</span> <span>DIVORCED</span> <span>Baltimore</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>10. CITY OR TOWN OF DEATH</span> <span>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</span> <span>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</span> <span>12b. KIND OF BUSINESS OR INDUSTRY</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Towson</span> <span>St. Joseph Hospital</span> <span>Metal Lather</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</span> <span>13b. COUNTY</span> <span>13c. CITY OR TOWN</span> <span>13d. INSIDE CITY LIMITS?</span> <span>13e. STREET AND NUMBER</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Md.</span> <span>Baltimore</span> <span>Baltimore</span> <span>YES</span> <span>NO</span> <span>6506 Hilltop Ave., 21206</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>14. FATHER'S NAME</span> <span>15. MOTHER'S MAIDEN NAME</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>John L. McDade</span> <span>Ethel</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</span> <span>16b. SOCIAL SECURITY NO.</span> <span>17. INFORMANT</span> <span>Address</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>yes</span> <span>213031964</span> <span>Mrs. Frances McDade</span> <span>same</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</span> <span>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>PART 1. DEATH WAS CAUSED BY:</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>IMMEDIATE CAUSE (a)</span> <span>1621</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Acute anemia</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>DUE TO, OR AS A CONSEQUENCE OF</span> <span>massive pulmonary hemorrhage</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>163X</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Carcinoma of right lung</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>19a. DATE OF OPERATION</span> <span>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</span> <span>20a. AUTOPSY?</span> <span>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>YES</span> <span>NO</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>21a. ACCIDENT WAS UNDERLYING</span> <span>21b. TIME OF INJURY</span> <span>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)</span> <span>HOUR A.M. Month Day Year</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>21d. INJURY OCCURRED</span> <span>21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)</span> <span>21f. LOCATION</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>While at work</span> <span>Not while at work</span> <span>Street or R.F.D. No.</span> <span>City or Town</span> <span>County</span> <span>State</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>22a. I certify that (X) (this hospital) attended the deceased from February 9, 1968, to February 9, 1968, that (X) (we) last saw the deceased alive on February 9, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.</span> </div> |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>22b. SIGNATURE</span> <span>22c. DATE SIGNED</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Reynaldo Orjuela-Gomez, M. D.</span> <span>February 10, 1968</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>22d. PHYSICIAN'S NAME (Type)</span> <span>22e. ADDRESS</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>7620 York Road, Towson 4, Maryland</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>23a. BURIAL, CREMATION, REMOVAL (Specify)</span> <span>23b. DATE</span> <span>23c. NAME OF CEMETERY OR CREMATORY</span> <span>23d. LOCATION (City or Town) (County) (State)</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>burial</span> <span>2-13-68</span> <span>Meadowridge Cem.</span> <span>Dorsey Howard Md.</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>24. FUNERAL DIRECTOR</span> <span>25a. REC'D BY REGISTRAR</span> <span>25b. REGISTRAR'S SIGNATURE</span> </div>  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="display: flex; justify-content: space-between;"> <span>Leonard J. Ruck, Inc. Baltimore, Md.</span> <span>DATE</span> <span>February 13 1968</span> </div>   |  |  |  |  |  |  |  |  |  |  |  |

1954

DEPARTMENT OF DEATH

0533

NAME: [illegible] DATE: [illegible]

ADDRESS: [illegible]

CITY: [illegible] STATE: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

TIME OF DEATH: [illegible]

SEX: [illegible] RACE: [illegible]

HEIGHT: [illegible] WEIGHT: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

PREVIOUS ILLNESS: [illegible]

PREVIOUS SURGERY: [illegible]

PREVIOUS TRAUMA: [illegible]

PREVIOUS DRUGS: [illegible]

PREVIOUS ALCOHOL: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02277

02265

|   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Frances</b>  |  |  | First <b>McDaniel</b>  |  |  | Middle  |  |  | Last  |  |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>4</b> Year <b>68</b> |  |  | 2b. HOUR<br><b>4:50</b> PM                                     |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>Colored</b>  |  |  | 5. DATE OF BIRTH<br><b>12-14-10</b>   |  |  | 6. AGE (In years lost birthday)<br><b>57</b> YRS.                                 |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                       |  |  | IF UNDER 24 HRS.<br>HOURS MIN.                                 |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>So. Carolina</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>usa</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Balto. County</b> Md.                                    |  |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Greater Balto. Med Center</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House wife</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |  | 13b. COUNTY <b>BALTO.</b>  |  |  | 13c. CITY OR TOWN <b>BALTO.</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>1802 Thomas Ave</b>                |  |  |  |  |  |
| 14. FATHER'S NAME First <b>Sherman</b> Middle <b>Sander</b> Last <b>White</b>   |  |  | 15. MOTHER'S MAIDEN NAME First <b>Carrie</b> Middle <b>Sander</b> Last <b>White</b>                              |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br><b>Patients Chart.</b>   |  |  |   |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Arrest</b><br><b>410.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PROBABLE MYOCARDIAL INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>LONGSTANDING CORON-ART. DISEASE</b><br>lost <b>4201</b>      |  |  |  |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>CHRONIC BRONCHIAL ASTHMA</b>  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-2</b> , 19 <b>68</b> , to <b>2-4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-3</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Josefin Aguilar</b>  |  |  |  |  |  |   |  |  |   |  |  |   |  |  | 22c. DATE SIGNED<br><b>2/4/68</b>                              |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JANFNO C. AGULAR</b>   |  |  | 22e. ADDRESS<br><b>6701 n. CHARLES ST.</b>   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2-8-68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Me. Pk.</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>       |  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Arlington S. Phillips</b>  |  |  | ADDRESS<br><b>1727 N. Monroe Street</b>  |  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 13 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>                       |  |  |   |  |  |  |  |  |

MEDICAL CERTIFICATION

5138

1891-1892

2000

80422

1807-2021

Sherran Zorobek

2012-2013

Tracy Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

|   |  |  |  |  |  |  |  |  |  |                             |  |
|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|
| 02278   |  | 02266  |  |  |  |  |  |  |  |                             |  |
| 1. DECEASED-NAME (Type or print)  |  | First Middle Last  |  | 2a. DATE OF DEATH  |  | 2b. HOUR   |  |  |  |                             |  |
| JOHN  |  | WILLIAM  |  | McGRAIN, SR.   |  | Month 2 Day 21 Year 68 1:30p M   |  |  |  |                             |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS                  |  | IF UNDER 24 HRS. HOURS MIN. |  |
| Male  |  | Caucasian  |  | Nov. 1, 1885   |  | 82 YRS.  |  |  |  |                             |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |                             |  |
| Balto., Md.   |  | U. S. A.   |  |  |  | Baltimore  |  | Md.  |  |                             |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                             |  |
| Towson  |  | Greater Balto. Med. Center   |  | Customs Service  |  | U.S. Gov't.  |  |  |  |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |                             |  |
| Md.   |  | Balto.   |  | Towson   |  |  |  | 34 Willow Ave.                               |  |                             |  |
| 14. FATHER'S NAME   |  | First Middle Last  |  | 15. MOTHER'S MAIDEN NAME   |  | First Middle Last  |  |  |  |                             |  |
| John  |  | McGrain  |  | Julia  |  | Clooney  |  |  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |  |  |                             |  |
| No  |  | 218-36-0302  |  | John W. McGrain, Jr.   |  | (Same)   |  |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4129</u> |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                     |  |  |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/21, 1968</u> , to <u>2/21, 1968</u> , that (I) (we) last saw the deceased alive on <u>2/21, 1968</u> , and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |                             |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |  |  |                             |  |
| John E. Adams   |  | 2/21/68  |  | John E. Adams, M.D.  |  | Greater Baltimore Medical Center   |  |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |                             |  |
| Burial  |  | 2/24/68  |  | New Cathedral  |  | Balto., Md.  |  |  |  |                             |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |                             |  |
| H.W. Jenkins & Sons Co.   |  | 4905 York Rd.  |  | FEB 26 1968  |  |  |  |  |  |                             |  |
| Balto., Md.   |  |  |  |  |  |  |  |  |  |                             |  |

08388

RECORD OF DEATH

08388

John S. Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18-Pt. 2 Film 397

2-14-68 ams

02279

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02267

|  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>EDGAR</b>   |  |  | First <b>FRANKLIN</b>  |  |  | Middle <b>MARLER</b>  |  |  | Last   |  |  | 2a. DATE OF DEATH<br>Month <b>FEB</b> Day <b>11</b> Year <b>1968</b> |  |  | 2b. HOUR<br><b>1.55.P.M.</b>                     |  |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br><b>4-15-1894</b>  |  |  | 6. AGE (In years<br>lost birthday)<br><b>73</b> YRS.                               |  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                     |  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.                                  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Mt. Wilson State Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>CRANE OPERATOR</b>   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>NONE</b>                                |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived,<br>admission) STATE <b>MARYLAND</b>  |  |  | 13b. CITY OR TOWN<br><b>FREDERICK</b>  |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  | 13e. STREET AND NUMBER<br><b>240 E. 7TH STREET</b>                                 |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First <b>WILLIAM</b> Middle <b>MARLER</b> Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>IDA</b> Middle <b>FOX</b> Last  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>217-16-2216</b>   |  |  | 17. INFORMANT<br>Address<br><b>Records, Mt. Wilson State Hospital</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>485X</b> IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILAT.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                      |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>471X Far advanced pulmonary tuberculosis</b>   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>YES</b> |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-19-</b> , 19 <b>68</b> , to <b>2-11-</b> , 19 <b>68</b> , that (I) (we) last<br>saw the deceased alive on <b>2-11-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.          |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Wm. Newcomer</b>  |  |  | DEGREE   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>2-11-1968</b>   |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type) <b>Wm. Newcomer, M.D.</b>  |  |  | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify) <b>BURIAL</b>   |  |  | 23b. DATE<br><b>2-14-1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mount Olivet Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Frederick, Frederick, Md.</b>  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Robert E. Dailey &amp; Son</b>  |  |  | ADDRESS<br><b>Frederick, Md.</b>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 13 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                 |  |  |  |  |  |  |  |  |

03330

03330

03330

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

0-111

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove above papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

| 02280   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02268  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | HOURS MIN  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| MARVIN WINFIELD MEREDITH  |  |  |  |  |  |  |  |  |  | FEBRUARY 16 1968   |  |  |  |  |  |  |  |  |  | 11:10 PM   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)   |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |  |  |  |  |  |  |
| MALE  |  |  |  |  |  |  |  |  |  | WHITE  |  |  |  |  |  |  |  |  |  | JUNE 6, 1922   |  |  |  |  |  |  |  |  |  | 45 YRS.   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH  |  |  |  |  |  |  |  |  |  | Md.                         |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| MARYLAND  |  |  |  |  |  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | BALTIMORE   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| FORT HOWARD   |  |  |  |  |  |  |  |  |  | HOSPITAL VETERANS ADMINISTRATION   |  |  |  |  |  |  |  |  |  | LABORER  |  |  |  |  |  |  |  |  |  | FORESTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| MARYLAND  |  |  |  |  |  |  |  |  |  | DORCHESTER CAMBRIDGE   |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | RFD # 3   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| MARTIN MEREDITH   |  |  |  |  |  |  |  |  |  | TIVOLA RUARK   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT Address  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| YES   |  |  |  |  |  |  |  |  |  | WW II 218 16 5038  |  |  |  |  |  |  |  |  |  | CLINICAL RECORDS, VA HOSP, FT HOWARD, MD   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1459 CARCINOMA OF ORAL CAVITY WITH METASTASIS DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Mo  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 144X   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 1/22/68, 19, to 2/16/68, 19, that (X) (we) last saw the deceased alive on 2/16/68, 19, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Elsa M. Goris  |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED 2/17/68   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) ELSA M GORIS, MD   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  |  |  |  |  |  |  |  |  | 23b. DATE Feb 20, 1968   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY Spedden-Seward Cemetery   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) RFD #3, Cambridge, Maryland |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR LaCompte Funeral Home, Cambridge, Md   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR FEB 23 1968  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |

03330

03330

WOLFE 8811 1008 1100

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200

SS01 8 200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00  
03  
1

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                     |   |  |   |  |   |   |  |  |
|---|--|-------------------------------------|---|--|---|--|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                     |   |  |   |  |   |   |  |  |
| 02281   |  |                                     |   |  | 02269   |  |   |   |  |  |
| 1. PLACE OF DEATH   |  |                                     |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |   |   |  |  |
| a. COUNTY<br><b>BALTO</b> MARYLAND  |  |                                     |   |  | a. STATE<br><b>MD</b> b. COUNTY<br><b>BALTO</b>   |  |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ESSEX</b>  |  |                                     | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ESSEX</b>                                |  |   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>327 UPPERLANDING</b>   |  |                                     |   |  | d. STREET ADDRESS<br><b>327 UPPERLANDING</b>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |                                     |   |  | 4. DATE OF DEATH  |  |   |   |  |  |
| First Middle Last<br><b>MARION E. MEYER</b>   |  |                                     |   |  | Month Day Year<br><b>FEB 20 1968</b>  |  |   |   |  |  |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>W</b>        |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>5/19/08</b>                               |   | 9. AGE (In years last birthday)<br><b>59</b> yrs.   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>  |  |                                     |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MD</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |
| 13. FATHER'S NAME<br><b>FRANCIS SELTZER</b>   |  |                                     |   |  | 14. MOTHER'S MAIDEN NAME<br><b>P</b>  |  |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  |                                     | 16. SOCIAL SECURITY NO.<br><b>NO</b>  |  | 17. INFORMANT<br><b>EDWARD MEYER</b>  |  |   | Address<br><b>ABOVE</b>   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>410.9</b><br>DUE TO (b) <b>Chronic Myocarditis</b><br>DUE TO (c) <b>Rheumatic Endocarditis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                     |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>2 yrs</b><br><b>5 yrs</b>                 |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>4201</b>  |  |                                     |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                     |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                              |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1967</b> to <b>Feb 20, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 18, 1968</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.  |  |                                     |   |  |   |  |   |   |  |  |
| 22a. SIGNATURE<br><b>J.M. Baumgardner</b>   |  |                                     |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>2/20/68</b>                                |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>J.M. Baumgardner</b>   |  |                                     |   |  | 22d. ADDRESS<br><b>BALTO 21237</b>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>2/23/68</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATL. CEM</b>  |   |  | 23d. LOCATION (City, town or county) (State)<br><b>BALTO. MD.</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>   |  |                                     |   |  | ADDRESS<br><b>300 MACE</b>  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 23 1968</b>                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |

93320

11 FEB 1964

93320

Q10

17225

2. 11 31

11 31

11 31

11 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

2

VR A15 (4)  
30M REV. 1/68

| 02282  |  |  |  |  |  |  |  |  |  | 02270  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <b>Margaret</b>   |  |  |  |  | First <b>B.</b> Middle <b>B.</b> Last <b>Middlekauff</b>   |  |  |  |  | 2a. DATE OF DEATH <b>Feb. 20, 1968</b>   |  |  |  |  | 2b. HOUR <b>M</b>  |  |  |  |  |   |  |  |  |  |
| 3. SEX <b>female</b>   |  |  |  |  | 4. RACE <b>white</b>   |  |  |  |  | 5. DATE OF BIRTH <b>July 29, 1886</b>  |  |  |  |  | 6. AGE (In years last birthday) <b>81</b> YRS.   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Stoneleigh</b>  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Armaccost Nursing Home</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Agent</b>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>   |  |  |  |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  |  |  |  | 13b. COUNTY <b>Balto.</b>  |  |  |  |  | 13c. CITY OR TOWN <b>Balto.</b>  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER <b>308 Regester Ave.</b>         |  |  |  |  |
| 14. FATHER'S NAME First <b>William</b> Middle <b>Bohn</b> Last <b>Bohn</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Theresa</b> Middle <b>Theresa</b> Last <b>Theresa</b>                    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>no</b> (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>319-32-0792</b>  |  |  |  |  | 17. INFORMANT Address <b>J. Carroll Power Equitable Bldg. #1</b>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221 none</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION <b>none</b>   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>2/15/68</b> to <b>2/20/68</b> , that (1) (we) last saw the deceased alive on <b>2/20/68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE <b>Dr. Alan Tapper</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <b>2/23/68</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>DELETED DELETED DELETED</b> 22e. ADDRESS <b>7501 York Rd. #4</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  |  |  | 23b. DATE <b>2/23/68</b>   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>                          |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |
| 25a. REC'D BY REGISTRAR <b>FEB 26 1968</b>   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |

03230

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948

1948



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 19. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film U396 2/20/68  
02283  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
02271

|  |                     |   |  |  |  |   |  |
|--|---------------------|---|--|--|--|---|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last<br><b>HAZEL Jeannette MILLER</b>  |                     |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year<br><b>Feb 20 1968</b> |  |  | 2b. HOUR-<br><b>7:15 P M</b>  |  |
| 3. SEX<br><b>F</b>   | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br><b>April 16, 1901</b>   | 6. AGE (in years last birthday)<br><b>66 YRS</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>Feb 26 1968</b> |   | 2d. HOUR<br><b>8 P M</b>                                       |
| 7a. BIRTHPLACE (State or foreign country)<br><b>md.</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH<br><b>Balto.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Parkton</b>  |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>York Rd.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cwn Home</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>md.</b>  |                     | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Parkton</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>York Rd.</b>  |                     | 14. FATHER'S NAME First Middle Last<br><b>William Uppercue</b>                                  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>unknown</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>   |                     | 16b. SOCIAL SECURITY NO.<br><b>220-14-7175</b>  |  | 17. INFORMANT ADDRESS<br><b>Ellen Perry, York Rd., Parkton, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>402X Hypertensive Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>443X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |                     |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Instant</b> |
| 19a. DATE OF OPERATION   |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                     | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br><b>19</b>                             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                     |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>A. M. France</b>  |                     | EXAMINER'S NAME (Type)<br><b>A. M. FRANCE</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county)<br><b>PARKTON, MD</b> |  | 22b. DATE SIGNED<br><b>2/20/68</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 23b. DATE<br><b>2/23/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wiseburg Cem.</b>   |  | 23d. LOCATION (City or town) (County) (State)<br><b>White Hall, Balto., Md.</b>                 |  |
| 24. FUNERAL DIRECTOR<br><b>J. Jacob Hartenstein, New Freedom, Pa.</b>  |                     | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 23 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Jacobs</b>  |  |

02527

STATE OF TEXAS  
COUNTY OF DALLAS

02528

STATE OF TEXAS  
COUNTY OF DALLAS

Know all men to these presents, that \_\_\_\_\_  
of the County of \_\_\_\_\_ State of \_\_\_\_\_  
do hereby certify that \_\_\_\_\_  
is the true and correct owner of the \_\_\_\_\_  
situated in the \_\_\_\_\_  
County of \_\_\_\_\_ State of \_\_\_\_\_  
and that the same is subject to the \_\_\_\_\_  
of the \_\_\_\_\_  
and that the same is subject to the \_\_\_\_\_  
of the \_\_\_\_\_

*[Signature]*

*[Signature]*  
A. H. F. K. A. V. E.

Witness my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_  
1968.

FEB 27 1968

Approved by Deputy Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| M  |  |  |  |  |  |  |  |  |  | 02284   |  |  |  |  |  |  |  |  |  | MAY 1968  |  |  |  |  |  |  |  |  |  | 02272  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)<br>Henry J. Miller  |  |  |  |  |  |  |  |  |  | 3. SEX<br>Male  |  |  |  |  |  |  |  |  |  | 4. RACE<br>White  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>December 26, 1890                                |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)<br>77 YRS.  |  |  |  |  |  |  |  |  |  | 7a. BIRTHPLACE (State or foreign country)<br>Maryland            |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore, Md.                |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Hydes   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Ridgeview Farm  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Insurance  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |  |  |  |  |  |  |  | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Hydes             |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER<br>Ridgeview Farm Hydes, Md. |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Henry Miller  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Teresa Deiter   |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>Yes, no, or (unknown) Yes WWI   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>212-10-4038                              |  |  |  |  |  |  |  |  |  | 17. INFORMANT<br>Mrs. Mary M. Miller  |  |  |  |  |  |  |  |  |  | Address<br>Ridgeview Farm Hydes, Md.                             |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease with</u><br><u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Old Myocardial Infarction</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____ |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 years</u>  |  |  |  |  |  |  |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4201</u><br><u>Diabetes Mellitus</u><br><u>17 years</u> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Feb.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2 Feb.</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br><u>Com. H. Ramsey</u><br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br><u>2/23/68</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS  |  |  |  |  |  |  |  |  |  | 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>2/26/68   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. John's Long Green   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Long Green, Md. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks  |  |  |  |  |  |  |  |  |  | Towson 1050 York Rd. 21204  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 26 1968   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jones</u>                   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

03380

03380

03380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
| 02285   |  |  |  |   |  |  |  | 02273  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>MARTIN LUTHER MILLER  |  |  | 2a. DATE OF DEATH Month Day Year<br>FEB. 14 1968   |   |  | 2b. HOUR<br>11.55 AM   |  |  |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>4-5-01  |  | 6. AGE (In years last birthday)<br>66 YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                     |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore County, Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Mt. Wilson   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Mt. Wilson State Hosp. |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>LABORER |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Contractor            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND   |  |  | 13b. COUNTY<br>FREDERICK   |   | 13c. CITY OR TOWN<br>THURMONT  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |
| 14. FATHER'S NAME First Middle Last<br>CHARLES MILLER   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>UNKNOWN  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>NONE   |   | 17. INFORMANT Address<br>Records, Mt. Wilson State Hospital  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) COR PULMONALE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) OBSTRUCTIVE AIRWAY DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) PULM T.B. FAR ADVANCED ACTIVE<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>0021 |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-5-1967, to 2-14-1968, that (I) (we) last saw the deceased alive on 2-14-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br>W. Newcomer   |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (Type) William Newcomer, M.D.   |  |  |  |   | 22e. ADDRESS Mount Wilson, Maryland  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br>2-18-68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>United Brethren Cem.  |  | 23d. LOCATION (City or Town) (County) (State)<br>Thurmont Fred. Co. Md.                            |  |  |  |
| 24. FUNERAL DIRECTOR Raymond E. Guaga   |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 20 1968  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |

ETSSO

CHIAO TO 3-11-123

2850

6881 U S 854



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove rubber papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> <span>02286</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02274</span> </div>  |  |   |   |   |   |   |   |   |   |  |                                |
|---|--|---|---|---|---|---|---|---|---|--|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print)   |  |   | First Middle Last<br>Roland Thomas Miller   |   |   | 2a. DATE OF DEATH<br>Month Day Year<br>February 20, 1968  |   |   | 2b. HOUR<br>4:15 P.M.                           |  |                                |
| 3. SEX<br>male  |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH /<br>April 10, 1889  |   |   | 6. AGE (In years<br>last birthday)<br>76 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                  |  | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>W. Va.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.   |   | 8. MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore Md.   |   |   |   |  |                                |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>SPRING GROVE STATE HOSP. |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>electrician |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>retired |  |                                |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Md.   |  |   | 13b. COUNTY<br>Balto.   |   | 13c. CITY OR TOWN<br>Lansdowne  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>408 First Avenue      |  |                                |
| 14. FATHER'S NAME<br>First Middle Last<br>Daniel W. Miller  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Anna Hockenberry   |   |   |   |   |   |   |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>216-05-2413   |   | 17. INFORMANT<br>Mrs. Clara E. Miller Address: 408 First Ave.<br>Records: SPRING GROVE STATE HOSPITAL |   |   |   |   |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction<br>410.9<br>DUE TO, OR AS A CONSEQUENCE OF with chronic abtrial fibrillation<br>(b) Arteriosclerotic Cardiovascular Ht. Dis. 7 yrs.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerosis, Generalized, Senile 7 yrs.<br>4201 |  |   |   |   |   |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>10 min. |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Benign Prostatic Hypertrophy with chronic cystitis & urinary reten.   |  |   |   |   |   |   |   |   |   |  |                                |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |  |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |   |   |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |   |   |   |   |   |  |                                |
| 22a. I certify that (x) (this hospital) attended the deceased from March 25, 19 61, to Feb. 20, 19 68, that (x) (we) lost<br>saw the deceased alive on Feb. 20, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |   |   |   |   |   |  |                                |
| 22b. SIGNATURE<br>  |  |   |   |   |   |   |   | 22c. DATE SIGNED<br>2-20-68   |   |  |                                |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Anthony J. Young, M.D.   |  |   |   | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228  |   |   |   |   |   |  |                                |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>2/22/68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine Park   |   |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Md.                                  |   |   |  |                                |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 23 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>  |   |   |   |  |                                |

MEDICAL CERTIFICATION

46 TSSG

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|  |  |  |  |  |  |   |  |  |                                       |  |                            |  |  |
|--|--|--|--|--|--|---|--|--|---------------------------------------|--|----------------------------|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Alice</b>   |  |  |  | First <b>H.</b> Middle <b>Mitchell</b>   |  | Last  |  | 2a. DATE OF DEATH <b>22</b> Feb. Month <b>23</b> Day Year <b>68</b>  |                                       |  | 2b. HOUR <b>12:10</b> AM   |  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>W.</b>  |  | 5. DATE OF BIRTH <b>Sept 3, 1882</b>   |  |   | 6. AGE (In years last birthday) <b>85</b> YRS. |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN |  | IF UNDER 24 HRS. HOURS MIN |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.   |  |  |                                       |  |                            |  |  |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Caton Ridge Nursing H</b>                              |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY     |  |                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Lansdowne</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER <b>22 Clyde Avenue</b>                        |                                       |  |                            |  |  |
| 14. FATHER'S NAME First <b>George</b> John Middle <b>Driver</b> Last <b>Driver</b>   |  | 15. MOTHER'S MAIDEN NAME First <b>Catherine</b> Scott Middle Last  |  |  |  |   |  |  |                                       |  |                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. <b>214-5601173</b>  |  | 17. INFORMANT Address <b>Mrs. Sarah E. Colhover, 1327 Aster Drive</b>  |  |   |  |  |                                       |  |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b><br><b>485X</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>485X</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |  |  |   |  |  |                                       |  |                            | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>ASCVD - Senile - Generalized Arteriosclerosis</b>   |  |  |  |  |  |   |  |  |                                       |  |                            |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                       |  |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |                                       |  |                            |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |                                       |  |                            |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-2-1967</b> , to <b>2-23-1968</b> , that (I) (we) last saw the deceased alive on <b>2-23-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |  |  |  |  |   |  |  |                                       |  |                            |  |  |
| 22b. SIGNATURE <b>Cesar Valle Cervero</b>  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED   |  |   |  |  |                                       |  |                            |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>CESAR VALLE CERVERO</b>  |  | 22e. ADDRESS <b>8624 Liberty Rd</b>  |  |  |  |   |  |  |                                       |  |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE <b>2-26-1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>                |  |  |                                       |  |                            |  |  |
| 24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR <b>FEB 29 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |  |                                       |  |                            |  |  |

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

02287

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

02288

02276

|  |                                  |   |  |  |  |   |   |
|--|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Baltimore</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson 21204</u>  |                                  |   | c. LENGTH OF STAY IN 1b<br><u>2 1/2 yrs.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>917 Dunellen Drive</u>  |                                  |   |  | d. STREET ADDRESS<br><u>917 Dunellen Drive</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Alice</u> Middle <u>Maude</u> Last <u>Mitchell</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>February</u> Day <u>6</u> Year <u>1968</u>  |  |   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 11, 1872</u>    | 9. AGE (In years last birthday)<br><u>95</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Can Home</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Pennsylvania</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Christian Estricher</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Emily C. Orr</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br>Address <u>Mrs. Helen Gorman, 917 Dunellen Dr., Towson</u>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC HEART DISEASE</u><br><u>4129</u><br>DUE TO (b) <u>GENERALIZED ARTERIO-SCLEROSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) <u>  </u> |                                  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>  </u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>4200</u>   |                                  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> o.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>MAY</u> , 19 <u>67</u> , to <u>FEB 6</u> , 19 <u>68</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>FEB 4</u> , 19 <u>68</u> , and that death occurred on <u>9:20 A</u> M, from causes on and the date stated above.  |                                  |   |  |  |  |   |   |
| 22a. SIGNATURE<br><u>T. C. Siwinski</u>  |                                  |   |  | 22b. DATE SIGNED<br><u>6 FEB 68</u>  |  | 22c. PHYSICIAN'S NAME (Type)<br><u>T. C. Siwinski, M.D.</u>                                       |   |
| 22d. ADDRESS<br><u>206 W. Penna. Ave., Towson, Md. 21204</u>   |                                  |   |  |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal/ Burial</u>  |                                  | 23b. DATE THEREOF<br><u>Feb. 10, 1968</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Washington, Pa.</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>New Washington, Pa.</u>                       |   |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Md.</u>   |                                  |   |  | 25a. REC'D BY REGISTRAR<br><u>FEB 8 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. J...</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF AGRICULTURE  
OFFICE OF THE SECRETARY OF AGRICULTURE

CERTIFICATE OF ANALYSIS

1850

1850

| ANALYSIS OF                            |                |
|--|----------------|
| FERTILIZER                             |                |
| No. 1                                  |                |
| 1. Name of Fertilizer                  | Superphosphate |
| 2. Name of Manufacturer                | W. A. R. Co.   |
| 3. Name of Dealer                      | W. A. R. Co.   |
| 4. Name of Buyer                       | W. A. R. Co.   |
| 5. Name of Shipper                     | W. A. R. Co.   |
| 6. Name of Receiver                    | W. A. R. Co.   |
| 7. Name of Warehouse                   | W. A. R. Co.   |
| 8. Name of Port of Origin              | W. A. R. Co.   |
| 9. Name of Port of Destination         | W. A. R. Co.   |
| 10. Name of Country of Origin          | W. A. R. Co.   |
| 11. Name of Country of Destination     | W. A. R. Co.   |
| 12. Name of Date of Analysis           | W. A. R. Co.   |
| 13. Name of Date of Shipment           | W. A. R. Co.   |
| 14. Name of Date of Receipt            | W. A. R. Co.   |
| 15. Name of Date of Delivery           | W. A. R. Co.   |
| 16. Name of Date of Payment            | W. A. R. Co.   |
| 17. Name of Date of Invoice            | W. A. R. Co.   |
| 18. Name of Date of Bill of Lading     | W. A. R. Co.   |
| 19. Name of Date of Receipt of Freight | W. A. R. Co.   |
| 20. Name of Date of Receipt of Freight | W. A. R. Co.   |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02289

Item #6 Film # 391 2/12/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02277

|   |                |  |   |   |  |   |  |  |  |
|---|----------------|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br>Carl Mohr   |                |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br>2 10 19 68         |   |  | 2b. HOUR OF DEATH<br>20   |  |  |  |
| 3. SEX<br>Male  | 4. RACE<br>Cau | 5. DATE OF BIRTH<br>6-22-1889  | 6. AGE (in years last birthday)<br>78 79 YRS.                   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>2 10 19 68  |  |  | 2d. HOUR<br>7:35 AM                          |
| 7a. BIRTHPLACE (State or foreign country)<br>Baltimore  |                | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>           |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |                | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>8801 Mayflower Rd. |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Self-employed |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Storekeeper |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |                | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Rossville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>8801 Mayflower Road 06 |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Charles Mohr  |                |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Elizabeth Kern |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No   |                | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>216-DB-5261A                  |   | 17. INFORMANT<br>May Reinhardt  |  |   | ADDRESS<br>8801 Mayflower Road 06  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4129 H-S-C-V-DISEASE<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } SENILITY<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                |  |   |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4221   |                |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |                |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br>Time       |   |  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M.<br>19                                    |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                       |   | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   | State  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                |  |   |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br>MELVIN B. DAVIS M.D.  |                |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |   | 22b. DATE SIGNED<br>2/10/68  |  |  |
| EXAMINER'S NAME (Type)<br>MELVIN B. DAVIS M.D.  |                |  |   | ADDRESS (Street, city, town, or county)<br>6800 MORTIMER RD<br>DUNDALK MARYLAND   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |                | 23b. DATE<br>2-13-1968   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Zion Cemetery   |  |   | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Co. Md.       |  |  |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home 7401 Belair Road   |                |  |   | ADDRESS<br>36   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 13 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Judge     |  |

05231

EXHIBIT 2 (CONTINUED OF 05231)

05231

05231

05231



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |   |   |   |  |  |
|--|--|---|--|---|--|---|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |   |   |  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>JOHN</b>  |  |   | First <b>T.</b> Middle <b>T.</b> Last <b>MORTON</b>  |   |  | 2a. DATE OF DEATH<br>Month <b>2-</b> Day <b>18-</b> Year <b>68</b>  |   | 2b. HOUR<br>M   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Negro</b>   |  | 5. DATE OF BIRTH<br><b>4-7-1892</b>   |  | 6. AGE (In years last birthday)<br><b>75</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS <b>1</b> DAYS <b>1</b> HOURS <b>1</b> MIN |  |  |
| 7a. BIRTHPLACE (State or foreign)<br><b>Charlotte, Va.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Dundalk</b> <i>Balto.</i> Md.  |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Sollors Point</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2708 Delk Court</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Miner</b>                         |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |  |   | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>1714 Laurens Street</b> |  |
| 14. FATHER'S NAME<br>First <b>Unk.</b> Middle <b>Unk.</b> Last <b>Unk.</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Unk.</b> Middle <b>Unk.</b> Last <b>Unk.</b>                      |   |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown  |  |   | 16b. SOCIAL SECURITY NO.<br><b>232-14-8310</b>   |   | 17. INFORMANT<br>Address<br><b>Mr. Alton W. Lewis 2708 Delk Court</b>                |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lung</b><br><b>1621</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>163X</b>  |  |   |  |   |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. _____ Month _____ Day _____ Year <b>19</b><br>P.M. _____ |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)              |  | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |  |   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1/2/68</b> , 19 <b>68</b> , to <b>2/18/68</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>2/18/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |  |   |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Heoc Patterson</b>  |  |   |  | DEGREE<br><b>PHYS.</b>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>2/19/68</b>                                  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |   |  | 22e. ADDRESS  |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-24-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Memorial Pk.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT F.H.</b>   |  |   |  | ADDRESS<br><b>1701 Laurens St.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 23 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                  |  |  |

025214

CHARTER OF 1914

025214

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

1 - 1 - 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |                          |  |  |   |  |  |                  |
|---|--|--|--------------------------|--|--|---|--|--|------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |                          |  |  |   |  |  |                  |
| CERTIFICATE OF DEATH  |  |  |                          |  |  |   |  |  |                  |
| 02291   |  |  |                          |  |  |   |  |  |                  |
| 02279   |  |  |                          |  |  |   |  |  |                  |
| 1. DECEASED-NAME (Type or print)  |  |  | First Middle Last        |  |  | 2a. DATE OF DEATH   |  |  | 2b. HOUR         |
| Louis   |  |  | MAZIER                   |  |  | February 11, 1968   |  |  | M                |
| 3. SEX  |  | 4. RACE  |                          | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                              |                  |
| MALE  |  | WHITE  |                          | JULY 12, 1885  |  | 82 YRS.   |  | MONTHS DAYS HOURS MIN.                       |                  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | Md.  |                  |
| MARYLAND  |  | U.S.A.   |                          |  |  | BALTIMORE   |  |  |                  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |                  |
| Catonville  |  | 1003 N. Rolling Rd.  |                          | Postal Clerk   |  | U.S. Gov't  |  |  |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                          | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET AND NUMBER                       |                  |
| MARYLAND  |  |  |                          | BALTIMORE  |  |   |  | 2613 WILKENS AVE                             |                  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME |  |  |   |  |  |                  |
| First Middle Last   |  |  | First Middle Last        |  |  |   |  |  |                  |
| Louis   |  |  | MAZIER                   |  |  | AMELIA  |  |  |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO. |  |  | 17. INFORMANT Address   |  |  |                  |
| NO  |  |  | NONE                     |  |  | 216-24-6062 ADULIN MAZIER 2613 WILKENS AVE.   |  |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                          |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |                          |  |  |   |  |  |                  |
| IMMEDIATE CAUSE (a) 4120 Acute myocardial failure   |  |  |                          |  |  |   |  | 2 wks  |                  |
| DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V. R. lesion   |  |  |                          |  |  |   |  | ?  |                  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |                          |  |  |   |  |  |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                          |  |  |   |  |  |                  |
| 4201 Pneumonia - Urinary tract infection  |  |  |                          |  |  |   |  |  |                  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                          | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |                  |
|   |  |  |                          |  |  |   |  |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |                  |
|   |  |  |                          |  |  |   |  |  |                  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |                          | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County State                                 |                  |
|   |  |  |                          |  |  |   |  |  |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15, 1968, to 2/11, 1968, that (I) (we) last saw the deceased alive on 2/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                          |  |  |   |  |  |                  |
| 22b. SIGNATURE  |  |  | DEGREE                   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  | 22c. DATE SIGNED |
| D.C. MacLaughlin  |  |  |                          |  |  |   |  |  | 2/12/68          |
| 22d. PHYSICIAN'S NAME (Type)  |  |  | 22e. ADDRESS             |  |  |   |  |  |                  |
| D.C. MacLaughlin  |  |  | 303 N. Rolling Rd.       |  |  |   |  |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                  |
| BURIAL  |  | 2-14-68  |                          | BALTIMORE  |  | BALTIMORE MD.   |  |  |                  |
| 24. FUNERAL DIRECTOR  |  |  |                          | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                  |
| Francis H. Miller 2101 Frederick Ave.   |  |  |                          | DATE FEB 13 1968   |  | Charles Judge   |  |  |                  |

02930

02930

02930

W. L. L. L.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |  |  |                                      |  |  |
|--|--|---|---|---|--|--|--------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |   |   |  |  |                                      |  |  |
| CERTIFICATE OF DEATH   |  |   |   |   |  |  |                                      |  |  |
| 02292  |  |   |   |   |  |  |                                      |  |  |
| 02280  |  |   |   |   |  |  |                                      |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Dora</i>  |  |   | First <i>A.</i> Middle <i>Naylor</i> Last                               |   |  | 2a. DATE OF DEATH<br><i>February</i> Month <i>15</i> , Year <i>1968</i>              |                                      | 2b. HOUR<br>M                                    |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br><i>June 13, 1871</i>  |  | 6. AGE (In years<br>lost birthday)<br><i>96</i> YRS.                                 |                                      | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><i>Balto. Co. Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |                                      |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Reisterstown</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><i>208 Main Street</i> |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><i>Housewife</i> |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) <i>Md.</i>  |  | 13b. COUNTY<br><i>Balto.</i>  |   | 13c. CITY OR TOWN<br><i>Reisterstown</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                      | 13e. STREET AND NUMBER<br><i>208 Main Street</i> |  |
| 14. FATHER'S NAME First <i>William</i> Middle <i>Allman</i> Last   |  |   | 15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>McClure</i> Last |   |  |  |                                      |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><i>None</i>   |   | 17. INFORMANT Address<br><i>Mrs. Mary Johnson Reisterstown, Md.</i>   |  |  |                                      |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocarditis - Decompensated</i><br><i>402 X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Hypertension</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Atherosclerosis</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 yrs</i><br><i>10 yrs</i><br><i>years</i> |  |   |   |   |  |  |                                      |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>443 X</i> <i>Viral infection - of respiratory tract</i>  |  |   |   |   |  |  |                                      |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |                                      |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |                                      |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |                                      |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-1-</i> , 19 <i>30</i> , to <i>2-15</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |                                      |  |  |
| 22b. SIGNATURE<br><i>James O. Saffell</i>  |  | 22c. DATE SIGNED<br><i>2-16-68</i>  |   | 22d. PHYSICIAN'S NAME (Type)<br><i>James O. Saffell</i>   |  |  |                                      |  |  |
| 22e. ADDRESS<br><i>Reisterstown, Md</i>  |  |   |   |   |  |  |                                      |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>2/19/68</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>All Saints</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Reisterstown, Md.</i>            |                                      |  |  |
| 24. FUNERAL DIRECTOR<br><i>J. F. Eline &amp; Sons Reisterstown, Md.</i>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>FEB 19 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                                     |                                      |  |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02293

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02281

|  |  |  |  |   |  |  |  |  |   |   |  |                                   |  |
|--|--|--|--|---|--|--|--|--|---|---|--|-----------------------------------|--|
| 1. DECEASED-NAME<br>(Type or Print) <u>MARY K. NAYLOR</u>  |  |  | First Middle Last                          |   |  | 20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <u>Feb</u> Day <u>27</u> Year <u>1968</u>  |  |  | 2b. HOUR <u>6A</u> M                                      |   |  |                                   |  |
| 3. SEX <u>Female</u>   |  | 4. RACE <u>White</u>   |  | 5. DATE OF BIRTH <u>March 16, 1934</u>  |  | 6. AGE (In years last birthday) <u>33</u> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS  |   | IF UNDER 24 HRS HOURS MIN.                                  |  |                                   |  |
| 7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <u>Baltimore</u> Md.                   |   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH <u>Parkton</u>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Sampson Rd.</u> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u> |   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>  |  |  |  | 13b. COUNTY <u>Baltimore</u>  |  | 13c. CITY OR TOWN <u>Parkton</u>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   | 13e. STREET AND NUMBER <u>Sampson Rd.</u>                   |  |                                   |  |
| 14. FATHER'S NAME First Middle Last <u>John T. Redman</u>  |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last <u>Blanche Bosley</u>   |  |  |   |   |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT ADDRESS <u>Mr. Louis W. Naylor Sampson Rd. Parkton, Md.</u>  |  |  |   |   |  |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY EMBO/1534</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u> |  |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4201</u>   |  |  |  |   |  |  |  |  |   |   |  |                                   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |   |   |  |                                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>19</u>                                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |   |   |  |                                   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |   |  |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |   |  |  |  |  |   |   |  |                                   |  |
| ACTUAL SIGNATURE <u>A. M. France</u> M.D.  |  |  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | 22b. DATE SIGNED <u>2/27/68</u>                           |   |  |                                   |  |
| EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>   |  |  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  | ADDRESS (Street, city, town, or county) <u>PARKTON MD</u> |   |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE <u>3/1/68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem. Cem.</u>                              |  |  |  | 23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Md.</u>                                   |   |   |  |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>   |  |  |  |   |  | 25a. REC'D BY REGISTRAR <u>FEB 29 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>  |   |   |  |                                   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
30M REV. 7-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
|---|--|---------|--|------------------|------------------------------------|--|---------------------------------|--|--|--|-----------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| CERTIFICATE OF DEATH  |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| 1. DECEASED-NAME (Type or print)  |  |         | First Middle Last  |                  |                                    | 2a. DATE OF DEATH  |                                 |  | 2b. HOUR   |  |                 |  |
| Mary Elizabeth Neumann  |  |         |  |                  |                                    | February 6 1968  |                                 |  | 3:15 AM  |  |                 |  |
| 3. SEX  |  | 4. RACE |  | 5. DATE OF BIRTH |                                    |  | 6. AGE (In years last birthday) |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS |  |
| Female  |  | White   |  | July 4th 1886    |                                    |  | 81 YRS.                         |  | MONTHS DAYS  |  | HOURS MIN.      |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY?   |                  |                                    | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | 9. COUNTY OF DEATH   |  |                 |  |
| State   |  |         | U S A  |                  |                                    |  |                                 |  | Baltimore County Md.   |  |                 |  |
| 10. CITY OR TOWN OF DEATH   |  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |                 |  |
| Cotonsville Md  |  |         | Forest Haven 315 Inglewood Ave   |                  |                                    |  |                                 |  |  |  |                 |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         | 13b. COUNTY  |                  |                                    | 13c. CITY OR TOWN  |                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                       |                 |  |
| 314 LORRAINE AVE MD   |  |         |  |                  |                                    | Baltimore  |                                 |  |  | 314 LORRAINE AVE                             |                 |  |
| 14. FATHER'S NAME   |  |         | 15. MOTHER'S MAIDEN NAME   |                  |                                    |  |                                 |  |  |  |                 |  |
| William Benton  |  |         | Mary Jubb  |                  |                                    |  |                                 |  |  |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown  |  |         | 16b. SOCIAL SECURITY NO.   |                  |                                    | 17. INFORMANT  |                                 |  | Address  |  |                 |  |
|   |  |         | 215-01-7776  |                  |                                    | Forest Haven Nursing Home  |                                 |  | Above  |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |  |                  |                                    |  |                                 |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                 |  |
| PART I. DEATH WAS CAUSED BY:  |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| IMMEDIATE CAUSE (a) <u>MATERNAL - PREMENSTRUAL CRAMP - UTERINE</u>  |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF <u>DISORDERS</u>   |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| (b) <u>PERIARTERIAL UTERINE ARTERIAL</u>  |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| (c) <u>MYOMETRIUM - ACUTE MYOMETRIAL INFARCT</u>  |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| 4221  |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| 19a. DATE OF OPERATION  |  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                 |  |
|   |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |                  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                 |  |  |  |                 |  |
|   |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)  |                  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                 |  |  |  |                 |  |
|   |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/4</u> , 19 <u>64</u> , to <u>2-6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 6</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |  |                  |                                    |  |                                 |  |  |  |                 |  |
| 22b. SIGNATURE  |  |         |  |                  |                                    |  |                                 |  | 22c. DATE SIGNED   |  |                 |  |
| <u>Dr. John Shaw</u>  |  |         |  |                  |                                    |  |                                 |  | 2/6/68   |  |                 |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |         |  |                  |                                    | 22e. ADDRESS   |                                 |  |  |  |                 |  |
| Dr. John Shaw   |  |         |  |                  |                                    | 5800 Edmondson Ave   |                                 |  |  |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         | 23b. DATE  |                  | 23c. NAME OF CEMETERY OR CREMATORY |  |                                 | 23d. LOCATION (City or Town) (County) (State)  |  |  |                 |  |
| Burial  |  |         | 2-10-68  |                  | Parkwood                           |  |                                 | Baltimore Md.  |  |  |                 |  |
| 24. FUNERAL DIRECTOR  |  |         |  |                  |                                    | 25a. REC'D BY REGISTRAR  |                                 |  | 25b. REGISTRAR'S SIGNATURE   |  |                 |  |
| Thelma A. Hoffman   |  |         |  |                  |                                    | DATE FEB 13 1968   |                                 |  | Charles Judge  |  |                 |  |

05225

05225

05225

05225

05225

05225

05225

05225

05225

05225

05225

05225

05225

05225

05225

05225

05225



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |   |  |  |  |  |                                |                   |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--------------------------------|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |  |  |  |  |                                |                   |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  |  |  |                                |                   |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>Mildred   |  |  | Middle<br>Harriet   |  |  | Last<br>Neumann   |  |  | 2a. DATE OF DEATH<br>Month 2 Day 27 Year 68        |  |                                | 2b. HOUR<br>1:05p |  |
| 3. SEX<br>Female  |  |  | 4. RACE<br>Cau   |  |  | 5. DATE OF BIRTH<br>June 28, 1898   |  |  | 6. AGE (In years lost birthday)<br>69 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |  | IF UNDER 24 HRS.<br>HOURS MIN. |                   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>N.Y., N.Y.   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore   |  |  | Md.  |  |                                |                   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto., Medical Center |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home   |  |  |  |  |                                |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |  | 13b. COUNTY<br>Balto.  |  |  | 13c. CITY OR TOWN<br>Lutherville  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>231 Cold Brook Rd. 21093 |  |                                |                   |  |
| 14. FATHER'S NAME<br>First ? Middle / Last Schroeder  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Unknown Middle Last  |  |  |   |  |  |   |  |  |  |  |                                |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) NO   |  |  | 16b. SOCIAL SECURITY NO.<br>None   |  |  | 17. INFORMANT<br>118 Union Ave.<br>X Perry Fun. Dir. Long Island, N.Y. 11563  |  |  |   |  |  |  |  |                                |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Pancytopenia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Malignant lymphoma</u><br>2002                       |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |                                |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |  |   |  |  |  |  |                                |                   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES                     |  |  |  |  |                                |                   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |                                |                   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |  |  |                                |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20, 1968, to 2/27, 1968, that (I) (we) last saw the deceased alive on 2/27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |  |  |                                |                   |  |
| 22b. SIGNATURE<br><i>John E. Adams</i>  |  |  | DEGREE   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br>2/27/68   |  |  |  |  |                                |                   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>John E. Adams, M.D.   |  |  | 22e. ADDRESS<br>6701 N. Charles Street   |  |  |   |  |  |   |  |  |  |  |                                |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>3-1-1968  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenfield Cem.   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Hemfstead, N.Y.                                |  |  |  |  |                                |                   |  |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks, Inc. 1217 St. Paul St. 21202   |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR<br>FEB 28 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |  |  |                                |                   |  |

524

9 9 9 9

329

93-247

9

100

- 99 -

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (4)  
30M REV. 1/68

| 02296   |  |  |  |   |  |  |  |   |  |  |  | 02284   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| NEWCOMB EUGENE DEWEY  |  |  |  |   |  |  |  |   |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br><b>NEWCOMB, EUGENE DEWEY</b>   |  |  |  |   |  |  |  |   |  |  |  | 2a. DATE OF DEATH<br><b>2</b> Month <b>25</b> Day <b>68</b> Year  |  |  |  |  |  |  |  | 2b. HOUR<br><b>1:50 PM</b>                      |  |  |  |  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  |  |  | 4. RACE<br><b>CAU.</b>  |  |  |  | 5. DATE OF BIRTH<br><b>23</b><br><b>12-26-01</b>  |  |  |  | 6. AGE (In years lost birthday)<br><b>66</b> YRS.   |  |  |  | IF UNDER 1 YEAR<br>MONTHS <b>1</b> DAYS <b>56</b>                    |  |  |  | IF UNDER 24 HRS.<br>HOURS <b>—</b> MIN <b>—</b> |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>GREATER BALTO. MED. CENTER</b> |  |  |  |   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>RETIRED Dist. gr. Milk Co.</b> |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |  |  |  | 13b. COUNTY <b>BALTO.</b>   |  |  |  | 13c. CITY OR TOWN <b>BALTO.</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |  |  |  | 13e. STREET AND NUMBER<br><b>110 LINDEN TERRACE</b>                  |  |  |  |   |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First <b>JOHN</b> Middle <b>16211</b> Last <b>NEWCOMB</b>   |  |  |  |   |  |  |  |   |  |  |  | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Vickers</b> Last <b>Vickers</b>  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  |  |  | 17. INFORMANT<br><b>Family records</b> Address  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Extensive liver metastasis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Bronchogenic Carcinoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>1621</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>1621</b>   |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |   |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1</b> 19 <b>68</b> , to <b>Feb. 25</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>Feb. 25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                        |  |  |  |   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Lilia C. Baldonado</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |   |  |  |  |   |  |  |  | 22c. DATE SIGNED<br><b>2-25-68</b>  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>LILIA C. BALDONADO</b>  |  |  |  |   |  |  |  |   |  |  |  | 22e. ADDRESS<br><b>GREATER BALTO. MEDICAL CENTER</b>  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>Feb. 28, 1968</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Memorial Cem. Cockeysville, Maryland</b>  |  |  |  |   |  |  |  | 23d. LOCATION (City or Town) (County) (State)                        |  |  |  |   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John Burns Spis</b> ADDRESS <b>Towson</b>  |  |  |  |   |  |  |  |   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 29 1968</b>  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>          |  |  |  |   |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |  |   |  |  |                        |  |
|--|--|---|--|--|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |  |   |  |  |                        |  |
| CERTIFICATE OF DEATH   |  |   |  |  |  |   |  |  |                        |  |
| 02297  |  |   |  |  |  |   |  |  |                        |  |
| 02285  |  |   |  |  |  |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |   | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |                        |  |
| FRANK  |  |   | HOWARD   |  |  | NICKENS   |  | Month 2- 19- 68 6A   |                        |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.                       |                        |  |
| Male   |  | Negro   |  | 1-1-1903   |  | 65 YRS.   |  |  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |                        |  |
| Virginia   |  | U.S.A.  |  |  |  | Balto Co CATONVILLE Md.   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                            |                        |  |
| Catonville   |  |   | Kidgeway Nursing Home  |  |  | Cement Finisher   |  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |   | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Maryland   |  |   |  |  | Balto.   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  | 1921 Ettings Street    |  |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |  |                        |  |
| First Middle Last  |  |   | First Middle Last  |  |  |   |  |  |                        |  |
| UNKNOWN  |  |   | UNKNOWN  |  |  |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   | Address  |  |                        |  |
| No.  |  |   | 218-01-1795  |  | Mrs. Mary Gaulding   |   | 1921 Etting Street   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thromb</u><br><u>151.9</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>Under</u> |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>151X</u>   |  |   |  |  |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>14 Feb</u> , 19 <u>68</u> , to <u>19 Feb</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>14 Feb</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE <u>William Goodman M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <u>14 Feb 68</u>  |  |   |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type) <u>William Goodman M.D.</u>   |  | 22e. ADDRESS <u>1334 Guilford Ave #522</u>  |  |  |  |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                        |  |
| Burial   |  | 2-22-68   |  | Mount Auburn Cem.  |  | Baltimore, Maryland   |  |  |                        |  |
| 24. FUNERAL DIRECTOR   |  | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |                        |  |
| MORTON & DYETT F.H. 1701 Laurens Street  |  | FEB 20 1968 <u>Charles Judge</u>  |  |  |  |   |  |  |                        |  |

0231

02382

STOKES

HOWARD

WATSON

1-1-1903

WATSON

WATSON

WATSON & WATSON, 1000 W. 10th St., St. Paul, Minn.

WATSON & WATSON, 1000 W. 10th St., St. Paul, Minn.

1-1-1903

WATSON & WATSON

WATSON

WATSON

WATSON & WATSON

WATSON & WATSON

WATSON & WATSON, 1000 W. 10th St., St. Paul, Minn.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <p>02298</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">02286</p> </div>  |  |  |   |   |   |   |  |   |   |   |  |
|---|--|--|---|---|---|---|--|---|---|---|--|
| 1. DECEASED-NAME (Type or print) <b>WILLIAM</b>   |  |  |   | First <b>B.</b> Middle <b>NOBLETTE</b> Last   |   | 2a. DATE OF DEATH <b>February</b> Month <b>20</b> , Day <b>1968</b> . Year                                      |  |   | 2b. HOUR <b>6:08</b> M  |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH <b>August 2, 1898.</b>   |   |   | 6. AGE (In years lost birthday) <b>69</b> YRS.                       |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b><br>IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                      |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Baltimore</b> Md.   |  |   |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Josephs Hosp.</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Mechanic</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  | 13b. COUNTY <b></b>  |   | 13c. CITY OR TOWN <b>Baltimore</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |  | 13e. STREET AND NUMBER <b>5917 Falkirk Road</b> |   |   |  |
| 14. FATHER'S NAME First <b>George</b> Middle <b></b> Last <b>Noblette</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b></b> Last <b>Storke</b>  |   |   |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO. <b>579-07-5746</b>                                  |   | 17. INFORMANT <b>Mrs. Emily S. Noblette</b> Address <b>(Same)</b>   |   |   |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>410.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic heart disease with</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b> |  |  |   |   |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one hour</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |  |   |   |   |   |  |   |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |   |   |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 7, 1944</b> , to <b>February 20, 1968</b> , that (H) (we) last saw the deceased alive on <b>February 20, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |  |   |   |   |  |
| 22b. SIGNATURE <b>E. J. Alessi</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |   |   | 22c. DATE SIGNED <b>2/22/68</b>   |  |   |   |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>E. J. Alessi</b>  |  |  |   |   |   | 22e. ADDRESS <b>6217 Harford Rd. Balto. Md.</b>   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>2/24/68.</b>  |   | 23c. NAME OF CEMETERY OR CREMATOR <b>Moreland</b>   |   | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>   |  |   |   |   |  |
| 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b> ADDRESS  |  |  |   |   |   | 25a. REC'D BY REGISTRAR <b>DATE FEB 23 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |   |   |  |

48384

48384

|                |                           |
|----------------|---------------------------|
| NAME           | JOSEPH, J.                |
| DATE OF BIRTH  | 1901                      |
| PLACE OF BIRTH | USA                       |
| EDUCATION      | High School               |
| RELIGION       | Catholic                  |
| STATUS         | Single                    |
| EMPLOYMENT     | None                      |
| RESIDENCE      | 123 Main St, New York, NY |
| REMARKS        | ...                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |   |   |  |  |
|--|--|--|--|--|--|---|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |   |   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  |  | Middle   |   | Last   |   | 2a. DATE OF DEATH<br>Month Day Year   |  |  |
| FRANK  |  |  | CASIMER  |  | NOVAK  |   |  |   | FEBRUARY 6 1968 10:45 AM  |  |  |
| 3. SEX<br>MALE   |  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>11/23/19   |   |  | 6. AGE (In years last birthday)<br>48 YRS.  |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>BALTIMORE, MARYLAND   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE COUNTY, Md.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>VET. ADM. HOSPITAL |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>BARTENDER  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>TAVERN                                 |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>BALTIMORE   |  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET AND NUMBER<br>2919 Putty Hill Road             |  |
| 14. FATHER'S NAME<br>First Middle Last<br>CASIMIR J. NOVAK   |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>ANNA CUSPER                                   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>YES   |  |  | 16b. SOCIAL SECURITY NO.<br>WW II  |  | 17. INFORMANT<br>MARY JANE NOVAK 325 BLACKSTONE BLVD TOWN HALL N.Y.                            |   |  | Address<br>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BACTERIAL SEPTICEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>BILATERAL CONFLUENT BRONCHOPNEUMONIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>CIRRHOSIS OF LIVER</u>   |  |  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>5710</u>  |  |  |  |  |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |   |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from <u>1/17/68</u> , 19 <u>68</u> , to <u>2/6/68</u> , 19 <u>68</u> , that (b) (we) last saw the deceased alive on <u>2/6/68</u> , 19 <u>68</u> , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br><u>John D. Talbert, M.D.</u>   |  |  |  |  |  |   |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><u>2/6/68</u>                          |  |
| 22d. PHYSICIAN'S NAME (Type)<br>JOHN D. TALBERT, M. D.   |  |  |  |  |  |   |  | 22e. ADDRESS<br>VAH FORT HOWARD, MARYLAND   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  |  | 23b. DATE<br><u>2-10-1968</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart of Mary Cemetery German Hill Rd. Balto. Md. |   |  | 23d. LOCATION (City or Town) (County) (State)<br>BALTO. MD.   |   |  |  |
| 24. FUNERAL DIRECTOR<br>KASZOROWSKI FUNERAL HOME<br>2525 Fleet St. Baltimore, Md.  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>FEB 13 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>James Judge</u>  |   |  |  |

MEDICAL CERTIFICATION

02330

02330

10:00 AM 10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |   |  |  |
|---|--|--|---|--|--|---|--|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |  |  |   |   |  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |  |   |  |  |   |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>Rose   |  |  | Middle<br>Violet  |  |  | Last<br>Novak   |   |  |  |
| 2a. DATE OF DEATH<br>February 28, 1968  |  |  |   |  |  | 2b. HOUR<br>6:30 p.m.   |  |  |   |   |  |  |
| 3. SEX<br>female  |  |  | 4. RACE<br>white  |  |  | 5. DATE OF BIRTH<br>December 13, 1898   |  |  | 6. AGE (In years<br>lost birthday)<br>69 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN           |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Baltimore, Md.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore, Md.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>2806 Taylor Avenue #34 |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>at home   |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Md.   |  |  | 13b. COUNTY<br>Balto.   |  |  | 13c. CITY OR TOWN<br>Balto.   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br>2806 Taylor Avenue 21234 |  |
| 14. FATHER'S NAME<br>First<br>Theodore Seidel   |  |  | Middle<br>Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Mary Miller  |  |  | Middle<br>Last  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>no   |  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>none                                 |  |  | 17. INFORMANT (Nephew)<br>Charles J. Novak, 733 N. Patterson Pk. Ave.   |  |  | Address   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u><br>174X DUE TO, OR AS A CONSEQUENCE OF <u>Carcinomatosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Lymphatic system</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of breast</u> |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>6 mos.<br>8 1/2 yrs. |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>170X  |  |  |   |  |  |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                           |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19 59</u> to <u>Feb. 28 19 68</u> , that (I) (we) last saw the deceased alive on <u>Feb. 28 19 68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |   |  |  |
| 22b. SIGNATURE<br><u>A. M. Bacon M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |  |  |   |  |  | 22c. DATE SIGNED<br>3/1/68  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. A.M. Bacon  |  |  |   |  |  | 22e. ADDRESS<br>2810 Taylor Avenue  |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>3/2/68   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Balto., Md.                                    |   |  |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home<br>3331 Brehms Lane #13  |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 4 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Jones   |   |  |  |



08300

08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300

08300 08300 08300 08300 08300



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 02301   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 02289   |  |  |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) <i>Stephen X O'Dwyer</i>   |  |  |  | First Middle Last  |  |  |  | 2a. DATE OF DEATH Month <i>2</i> Day <i>24</i> Year <i>68</i>   |  |  |  | 2b. HOUR <i>1 P</i>                          |  |
| 3. SEX <i>MALE</i>  |  | 4. RACE <i>White</i>                       |  | 5. DATE OF BIRTH <i>12/26/93</i>   |  |  |  | 6. AGE (In years last birthday) <i>74</i> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>New York City</i>  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>BALTO - County</i> Md.                 |  |   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Catonsville</i>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit</i>   |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>salesman</i> |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>   |  |  |  | 13b. COUNTY <i>BALTO.</i>  |  | 13c. CITY OR TOWN <i>Catonsville</i>                         |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 13e. STREET AND NUMBER <i>6 Locust Drive</i>                         |  |  |  |
| 14. FATHER'S NAME First Middle Last <i>Thomas W O'Dwyer</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary McDonald</i>  |  |  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>yes</i> (If yes give war or dates of service) <i>WWI</i>   |  |  |  | 16b. SOCIAL SECURITY NO. <i>081-03-2727</i>  |  | 17. INFORMANT Address <i>Elizabeth O'Dwyer - Same</i>        |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of large intestine</i>  |  |  |  |  |  |  |  |   |  |  |  | <i>8 mos.</i>                                |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>163X Rheumatoid Arthritis</i>   |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION <i>AUG 1967</i>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma Rt Lung</i>  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                         |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <i>Feb 21</i> , 19 <i>66</i> to <i>Feb 24</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Feb 21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. <i>I DID VIEW BODY AFTER DEATH.</i> |  |  |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE <i>John N. Snyder MD</i>   |  |  |  | DEGREE <i>MD</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  |  |  | 22c. DATE SIGNED <i>2/24/68</i>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>JOHN N. SNYDER M.D.</i>   |  |  |  | 22e. ADDRESS <i>6348 FREDERICK RD CATONSVILLE MD</i>   |  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>   |  |  |  | 23b. DATE <i>2-28-68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i> |  |   |  | 23d. LOCATION (City or Town) (County) (State) <i>BALTO. MD</i>       |  |  |  |
| 24. FUNERAL DIRECTOR <i>Ellsworth Armacost</i>  |  |  |  | ADDRESS <i>4600 Liberty Hgts Ave</i>   |  |  |  | 25a. REC'D BY REGISTRAR <i>Charles Judge</i>  |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                      |  |  |  |
| DATE <i>FEB 27 1968</i>   |  |  |  |  |  |  |  |   |  |  |  |  |  |

08288

CENTRAL DEPT.

08301

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*

*[Faint vertical text on the right margin, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  |
| 02302   |  |  |  |  |  |   |  |  |   |  |  |
| 02290   |  |  |  |  |  |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>HANS  |  |  | Middle<br>OETTL   |  |  | Last<br>OETTL   |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>Cau.  |  |  | 5. DATE OF BIRTH<br>9/20/97   |  |  | 2a. DATE OF DEATH<br>2 Month 22 Day 68 Year   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Germany  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Balto. Maryland  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Balto. Med. Cen. |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Machinist  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Beth. Steel  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |  | 13b. COUNTY<br>Baltimore   |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First<br>Joseph  |  |  | Middle<br>Oetttl   |  |  | Last<br>Anna  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Anna   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>no   |  |  | 16b. SOCIAL SECURITY NO.<br>213-07-3515  |  |  | 17. INFORMANT<br>Address<br>Anna Oetttl (nee Ege), wife, above  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration</u><br>485X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Ileus</u><br>(c) <u>Bronchopneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>5701 Arteriosclerotic cardiovascular disease   |  |  |  |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes                     |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/5/1968, to 2/22/68, 1968, that (I) (we) last saw the deceased alive on 2/22 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>John E. Adams   |  |  |  |  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |  |  | 22c. DATE SIGNED<br>2/23/68   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>JOHN E. ADAMS, M.D.   |  |  |  |  |  | 22e. ADDRESS<br>Greater Baltimore Medical Center  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>2/26/68   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Balto., Md.                                    |  |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home<br>3331 Brehms Lane 21213  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>FEB 28 1968<br>DATE  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |

03305

03305

03305

03305

03305

03305

03305

03305

03305

03305

03305

03305

03305

03305

03305

03305



John S. Adams

03305

03305

03305

03305

03305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02303</div> <div> <div>02291</div> <div>02291</div> </div>   |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
|---|--|--|--|--|--------------------------|--|----------|--|--|--|-------------------|-------------------------|--|------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | First                    |  | Middle   |  | Last   |  | 2a. DATE OF DEATH |                         | 2b. HOUR                                     |                  |  |
| TERESA  |  |  |  |  | F.                       |  | OHLMEYER |  |  |  | FEBRUARY 22, 1968 |                         | 1:15 PM                                      |                  |  |
| 3. SEX  |  |  | 4. RACE  |  |                          | 5. DATE OF BIRTH   |          |  | 6. AGE (In years lost birthday)  |  |                   | IF UNDER 1 YEAR         |  | IF UNDER 24 HRS. |  |
| FEMALE  |  |  | WHITE  |  |                          | MAY 13, 1898   |          |  | 69 YRS.  |  |                   | MONTHS DAYS             |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                          | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |          |  | 9. COUNTY OF DEATH   |  |                   | Md.                     |  |                  |  |
| MARYLAND  |  |  | U.S.A.   |  |                          |  |          |  | BALTIMORE  |  |                   |                         |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |          |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                   |                         |  |                  |  |
| TOWSON  |  |  | ST. JOSEPH HOSPITAL  |  |                          | HOMEMAKER  |          |  |  |  |                   |                         |  |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |                          | 13c. CITY OR TOWN  |          |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                   | 13e. STREET AND NUMBER  |  |                  |  |
| MARYLAND  |  |  |  |  |                          | BALTIMORE  |          |  |  |  |                   | 5204 A LOCH RAVEN BLVD. |  |                  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME |  |          |  |  |  |                   |                         |  |                  |  |
| First Middle Last   |  |  |  |  | First Middle Last        |  |          |  |  |  |                   |                         |  |                  |  |
| Robert Flanigan   |  |  |  |  | Louise Grebe             |  |          |  |  |  |                   |                         |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  |  |  | 16b. SOCIAL SECURITY NO. |  |          |  |  | 17. INFORMANT Address                                |                   |                         |  |                  |  |
| no  |  |  |  |  | 216-44-0530              |  |          |  |  | Miss May Flanigan 5204 Loch Raven Blvd.              |                   |                         |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                          |  |          |  |  |  |                   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| IMMEDIATE CAUSE (a) <u>Recurrent myocardial infarction</u>  |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| 4109 (b) <u>coronary thrombosis</u>   |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| (c)   |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| 4201  |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                          | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |          |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                   |                         |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |          |  |  |  |                   |                         |  |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                          | 21f. LOCATION Street or R.F.D. No. City or Town County State   |          |  |  |  |                   |                         |  |                  |  |
| 22a. I certify that <u>10</u> (this hospital) attended the deceased from <u>JANUARY 24, 1968</u> , to <u>FEBRUARY 22, 1968</u> , that <u>10</u> (we) last saw the deceased alive on <u>FEBRUARY 22, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                          |  |          |  |  |  |                   |                         |  |                  |  |
| 22b. SIGNATURE <u>Reynaldo Orjuela-Gomez, M.D.</u> DEGREE <u>M.D.</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  |  |                          |  |          |  |  | 22c. DATE SIGNED <u>February 22, 1968</u>            |                   |                         |  |                  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Reynaldo Orjuela-Gomez, M.D.</u>  |  |  |  |  |                          |  |          |  |  | 22e. ADDRESS <u>7620 York Rd., Towson, Md. 21204</u> |                   |                         |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  |                          | 23c. NAME OF CEMETERY OR CREMATORY   |          |  | 23d. LOCATION (City or Town) (County) (State)  |  |                   |                         |  |                  |  |
| Burial  |  |  | 2/26/68  |  |                          | Druid Ridge  |          |  | Balto., Md.  |  |                   |                         |  |                  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  |                          |  |          |  |  | 25a. REC'D BY REGISTRAR DATE                         |                   |                         | 25b. REGISTRAR'S SIGNATURE                   |                  |  |
| Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Md. 21212  |  |  |  |  |                          |  |          |  |  | FEB 26 1968  |                   |                         | <u>Charles Judge</u>                         |                  |  |

POSSO

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

地址：上海南京路 100 号

1

• •

[illegible][illegible]

1967-08-01 10:30 AM Page 13

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1998: 1998-1999, 2000-2001, 2002-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011, 2012-2013, 2014-2015, 2016-2017, 2018-2019, 2020-2021, 2022-2023, 2024-2025, 2026-2027, 2028-2029, 2030-2031, 2032-2033, 2034-2035, 2036-2037, 2038-2039, 2040-2041, 2042-2043, 2044-2045, 2046-2047, 2048-2049, 2050-2051, 2052-2053, 2054-2055, 2056-2057, 2058-2059, 2060-2061, 2062-2063, 2064-2065, 2066-2067, 2068-2069, 2070-2071, 2072-2073, 2074-2075, 2076-2077, 2078-2079, 2080-2081, 2082-2083, 2084-2085, 2086-2087, 2088-2089, 2090-2091, 2092-2093, 2094-2095, 2096-2097, 2098-2099, 2100-2101, 2102-2103, 2104-2105, 2106-2107, 2108-2109, 2110-2111, 2112-2113, 2114-2115, 2116-2117, 2118-2119, 2120-2121, 2122-2123, 2124-2125, 2126-2127, 2128-2129, 2130-2131, 2132-2133, 2134-2135, 2136-2137, 2138-2139, 2140-2141, 2142-2143, 2144-2145, 2146-2147, 2148-2149, 2150-2151, 2152-2153, 2154-2155, 2156-2157, 2158-2159, 2160-2161, 2162-2163, 2164-2165, 2166-2167, 2168-2169, 2170-2171, 2172-2173, 2174-2175, 2176-2177, 2178-2179, 2180-2181, 2182-2183, 2184-2185, 2186-2187, 2188-2189, 2190-2191, 2192-2193, 2194-2195, 2196-2197, 2198-2199, 2200-2201, 2202-2203, 2204-2205, 2206-2207, 2208-2209, 2210-2211, 2212-2213, 2214-2215, 2216-2217, 2218-2219, 2220-2221, 2222-2223, 2224-2225, 2226-2227, 2228-2229, 2230-2231, 2232-2233, 2234-2235, 2236-2237, 2238-2239, 2240-2241, 2242-2243, 2244-2245, 2246-2247, 2248-2249, 2250-2251, 2252-2253, 2254-2255, 2256-2257, 2258-2259, 2260-2261, 2262-2263, 2264-2265, 2266-2267, 2268-2269, 2270-2271, 2272-2273, 2274-2275, 2276-2277, 2278-2279, 2280-2281, 2282-2283, 2284-2285, 2286-2287, 2288-2289, 2290-2291, 2292-2293, 2294-2295, 2296-2297, 2298-2299, 2300-2301, 2302-2303, 2304-2305, 2306-2307, 2308-2309, 2310-2311, 2312-2313, 2314-2315, 2316-2317, 2318-2319, 2320-2321, 2322-2323, 2324-2325, 2326-2327, 2328-2329, 2330-2331, 2332-2333, 2334-2335, 2336-2337, 2338-2339, 2340-2341, 2342-2343, 2344-2345, 2346-2347, 2348-2349, 2350-2351, 2352-2353, 2354-2355, 2356-2357, 2358-2359, 2360-2361, 2362-2363, 2364-2365, 2366-2367, 2368-2369, 2370-2371, 2372-2373, 2374-2375, 2376-2377, 2378-2379, 2380-2381, 2382-2383, 2384-2385, 2386-2387, 2388-2389, 2390-2391, 2392-2393, 2394-2395, 2396-2397, 2398-2399, 2400-2401, 2402-2403, 2404-2405, 2406-2407, 2408-2409, 2410-2411, 2412-2413, 2414-2415, 2416-2417, 2418-2419, 2420-2421, 2422-2423, 2424-2425, 2426-2427, 2428-2429, 2430-2431, 2432-2433, 2434-2435, 2436-2437, 2438-2439, 2440-2441, 2442-2443, 2444-2445, 2446-2447, 2448-2449, 2450-2451, 2452-2453, 2454-2455, 2456-2457, 2458-2459, 2460-2461, 2462-2463, 2464-2465, 2466-2467, 2468-2469, 2470-2471, 2472-2473, 2474-2475, 2476-2477, 2478-2479, 2480-2481, 2482-2483, 2484-2485, 2486-2487, 2488-2489, 2490-2491, 2492-2493, 2494-2495, 2496-2497, 2498-2499, 2500-2501, 2502-2503, 2504-2505, 2506-2507, 2508-2509, 2510-2511, 2512-2513, 2514-2515, 2516-2517, 2518-2519, 2520-2521, 2522-2523, 2524-2525, 2526-2527, 2528-2529, 2530-2531, 2532-2533, 2534-2535, 2536-2537, 2538-2539, 2540-2541, 2542-2543, 2544-2545, 2546-2547, 2548-2549, 2550-2551, 2552-2553, 2554-2555, 2556-2557, 2558-2559, 2560-2561, 2562-2563, 2564-2565, 2566-2567, 2568-2569, 2570-2571, 2572-2573, 2574-2575, 2576-2577, 2578-2579, 2580-2581, 2582-2583, 2584-2585, 2586-2587, 2588-2589, 2590-2591, 2592-2593, 2594-2595, 2596-2597, 2598-2599, 2600-2601, 2602-2603, 2604-2605, 2606-2607, 2608-2609, 2610-2611, 2612-2613, 2614-2615, 2616-2617, 2618-2619, 2620-2621, 2622-2623, 2624-2625, 2626-2627, 2628-2629, 2630-2631, 2632-2633, 2634-2635, 2636-2637, 2638-2639, 2640-2641, 2642-2643, 2644-2645, 2646-2647, 2648-2649, 2650-2651, 2652-2653, 2654-2655, 2656-2657, 2658-2659, 2660-2661, 2662-2663, 2664-2665, 2666-2667, 2668-2669, 2670-2671, 2672-2673, 2674-2675, 2676-2677, 2678-2679, 2680-2681, 2682-2683, 2684-2685, 2686-2687, 2688-2689, 2690-2691, 2692-2693, 2694-2695, 2696-2697, 2698-2699, 2700-2701, 2702-2703, 2704-2705, 2706-2707, 2708-2709, 2710-2711, 2712-2713, 2714-2715, 2716-2717, 2718-2719, 2720-2721, 2722-2723, 2724-2725, 2726-2727, 2728-2729, 2730-2731, 2732-2733, 2734-2735, 2736-2737, 2738-2739, 2740-27

U.S. DEPARTMENT OF AGRICULTURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |  |  |   |                    |   |  |
|---|--|---|---|--|--|---|--------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |  |  |   |                    |   |  |
| CERTIFICATE OF DEATH  |  |   |   |  |  |   |                    |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Joshua Gram  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>2 9 68         |  |  |   | 2b. HOUR<br>3 35 M |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>Feb. 26, 1889  |  | 6. AGE (In years lost birthday)<br>78 YRS.  |                    | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>UNKNOWN  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |                    |   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville Md   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Forest Haven N.H. |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>?   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                    |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Baltimore   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                    | 13e. STREET AND NUMBER<br>7712 Washington Boulevard     |  |
| 14. FATHER'S NAME First Middle Last<br>John Gram  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Unknown |  |  |   |                    |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.<br>212-18-5404   |   | 17. INFORMANT Address<br>Forest Haven N.H. 315 Ingleside Ave   |  |   |                    |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>4129 IMMEDIATE CAUSE (a) <u>Myocardial Infarction - Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial Infarction - Atherosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>4221 |  |   |   |  |  |   |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |                    |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |                    |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |                    |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/9, 1963, to 2-9, 1968, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |  |   |                    |   |  |
| 22b. SIGNATURE<br>Dr. John Shaw   |  |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>2/7/68  |                    |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. John Shaw   |  |   |   | 22e. ADDRESS<br>5800 Edmondson Ave   |  |   |                    |   |  |
| 23a. BURIAL, CREMATION, REINTERMENT<br>Buried   |  | 23b. DATE<br>2-9-68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. Nat. Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |                    |   |  |
| 24. FUNERAL DIRECTOR<br>Wm. E. Johnson 8521 Loch Raven Blvd. 21204  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 13 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |                    |   |  |

00300

00300

BRITISH OF INDIA

BRITISH

BRITISH OF INDIA

BRITISH OF INDIA

BRITISH OF INDIA

BRITISH OF INDIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

02305

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02293

|  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>EDGAR</b>   |  |  | First <b>JAMES</b>  |  |  | Middle <b>O'ROURK</b>   |  |  | Last  |  |  | 2a. DATE OF DEATH<br>Feb. Month <b>5</b> , Day <b>1968</b>                      |  |  | 2b. HOUR <b>6:45</b> P.M.                        |  |  |
| 3. SEX<br><b>Male</b>  |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br><b>Sept. 9, 1896</b>  |  |  | 6. AGE (In years last birthday)<br><b>71</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                |  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |   |  |  | Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>20 Admiral Blvd.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Machinist</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>   |  |  |   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>20 Admiral Blvd.</b>                               |  |  |  |  |  |
| 14. FATHER'S NAME<br><b>James W. O'Rourke</b>  |  |  | First<br><b>James W.</b>  |  |  | Middle<br><b>O'Rourke</b>   |  |  | Last  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Leah Rutter</b>                                  |  |  | First<br><b>Leah</b>                             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br><b>Dr. Thomas R. O'Rourke</b>  |  |  | Address<br><b>1101 W. Joppa Road.</b>   |  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>TERMINAL PNEUMONIA</b><br><b>342X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>PARKINSON'S Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>5 years</b> |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>350X</b>  |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                       |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 5</b> , 19 <b>68</b> , to <b>Feb 5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Feb 4</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |  |   |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>M.B. Davis</b>  |  |  | DEGREE  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED  |  |  |   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>M.B. Davis, M.D.</b>  |  |  | 22e. ADDRESS<br><b>6800 Mornington Road.</b>  |  |  |   |  |  |   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Feb. 7, 1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Md.</b>                           |  |  |   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Ullrich Funeral Home Dundalk, Md.</b>   |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 13 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |   |  |  |  |  |  |

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 02306   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                               |  |   |  | 02294   |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Goldie Gertrude Owens  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>2/19/68 |   |  | 2b. HOUR<br>M   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>2/16/89   |  | 6. AGE (In years last birthday)<br>79 YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Forest Haven Nursing Home |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Marcellus Owens   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Sarah A Bell   |  | 13e. STREET AND NUMBER<br>3907 Old York Rd.   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>216-09-2749   |  | 17. INFORMANT<br>Address<br>Mr. Wilbur R. Owens, 3510 Coolidge Ave. 21229   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary heart failure</u><br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Interdiction, severe pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Chronic uraemia; toxic shock; cachexia; decubitus</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Chronic uraemia; toxic shock; cachexia; decubitus</u> |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10 years</u> to <u>2/19/68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Jan 25 1968</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.  |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Dr. Louis P. Hamburger, Jr.</u>  |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><u>2/20/68</u>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Louis P. Hamburger, Jr.   |  |   |  | 22e. ADDRESS<br>1001 St. Paul St.   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>2/22/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Savage Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Savage Md.                                     |  |
| 24. FUNERAL DIRECTOR<br>Howard H. Hubbard, 4107 Wilkens Ave. 21229  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE FFB 23 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

48320

03300

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1903

REPORT OF THE

COMMISSIONERS OF THE

LAND OFFICE

FOR THE YEAR 1902

ALBANY:

JOHN P. KANE, PRINTING

1903

ALBANY: JOHN P. KANE, PRINTING

1903

48320

03300

STATE OF NEW YORK



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item# 02307 Film# G391 2/15/68 pn

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02295

|  |  |   |   |   |  |  |  |  |  |
|--|--|---|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>William Carroll Parks</i>   |  |   | 2a. DATE OF DEATH<br>Month <i>2</i> Day <i>3</i> Year <i>1968</i> |   |  | 2b. HOUR<br><i>11 P. M.</i>  |  |  |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br><i>6-19-08</i>  |  | 6. AGE (In years lost birthday)<br><i>59</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Md.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>G.B.M.C.</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Attorney</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Self-Employed</i>  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>   |  | 13b. COUNTY<br><i>Baltimore</i>   |   | 13c. CITY OR TOWN<br><i>Baltimore</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><i>2786 White Ave</i>                  |  |
| 14. FATHER'S NAME First Middle Last<br><i>Carroll Gordon Parks</i>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Bessie Cox</i>   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>no</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>2116057303</i>   |   | 17. INFORMANT<br><i>Mrs Edna F Parks</i>  |  | Address<br><i>Same</i>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><i>162.1</i> IMMEDIATE CAUSE (a) <i>Ch of the lungs &amp; related to brain &amp; bones</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____                                 |  |   |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>163X</i>  |  |   |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 4, 1967</i> , to <i>Feb. 3, 1968</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Marston S. John</i>   |  |   |   |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><i>Feb. 3, 1968</i>                          |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>ANASTASIA FABIZ</i>   |  | 22e. ADDRESS<br><i>G.B.M.C.</i>   |   |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>2/7/68</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parkwood</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore Maryland</i>   |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Leonard J Ruck Inc Baltimore Md</i>   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>5 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Marston S. John</i>   |  |  |  |

00000

STATE OF TEXAS

00000

FOR DEPOSIT  
IN THE  
STATE OF TEXAS



Library

00000

00000

00000

00000

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) A  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br>CERTIFICATE OF DEATH  |  |  |   |  |   |   |  |  |   |  |                             |
|---|--|--|---|--|---|---|--|--|---|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Rosa M. Patterson</b>  |  |  |   |  |   | 2a. DATE OF DEATH Month Day Year<br><b>2 2 68</b>   |  |  | 2b. HOUR M<br><b>68</b>                           |  |                             |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>Sept. 26, 1877</b>  |   |   | 6. AGE (In years last birthday)<br><b>90</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS                       |  | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |   |  |                             |
| 10. CITY OR TOWN OF DEATH<br><b>Parkville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2718 Glendale Rd</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                 |  |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Parkville</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>2718 Glendale Rd</b> |  |                             |
| 14. FATHER'S NAME First Middle Last<br><b>Samuel G Leight</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Pricilla Oshorn</b>   |   |   |  |  |   |  |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>No</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-07-5412A</b>   |  | 17. INFORMANT<br><b>Mrs. Ruth Smith</b>   |   |  | Address<br><b>(Same)</b>                           |   |  |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIO SCLEROSIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 YRS -</b>                       |  |  |   |  |   |   |  |  |   |  |                             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>332 X</b>  |  |  |   |  |   |   |  |  |   |  |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>          |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |  |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19<br><b>19</b>            |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |   |  |  |   |  |                             |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |   |  |  |   |  |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/10</b> , 19 <b>64</b> , to <b>2/2</b> , 19 <b>68</b> that (I) (we) last saw the deceased alive on <b>2/2</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |   |  |   |   |  |  |   |  |                             |
| 22b. SIGNATURE<br><b>Leonard Paul Berger M D</b>  |  |  |   |  |   | 22c. DATE SIGNED<br><b>2/2/68</b>   |  |  |   |  |                             |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Leonard Paul Berger M D</b>  |  |  |   |  |   | 22e. ADDRESS<br><b>8100 Harford Rd Baltimore Md 21234</b>   |  |  |   |  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/5/68.</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Providence Cemetery</b>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Gamber, Md.</b>                          |  |   |  |                             |
| 24. FUNERAL DIRECTOR<br><b>Leonard J Ruck Inc Baltimore Md</b>  |  |  |   |  |   | 25a. REC'D BY REGISTRAR<br><b>5 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |  |                             |

03304

03304

CONFIDENTIAL

100 100 100

100 100 100

100 100 100

100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

100 100 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |         |  |        |  |                          |  |  |
|---|---------|--|--------|--|--------------------------|--|--|
| 02309   |         | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |        |  |                          | 02297  |  |
| 1. DECEASED-NAME (Type or print)  |         | First  | Middle | Last   | 2a. DATE OF DEATH        |  | 2b. HOUR                                     |
| Anna  |         |  |        | Pazourek   | Month                    | Day  | Yr   |
| February  |         | 18   | 1968   | 4.45AM   |                          |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years lost birthday)  |                          | IF UNDER 1 YEAR  |  |
| Female  | White   | 8-21-89  |        | 78 YRS.  |                          | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                          | 9. COUNTY OF DEATH   |  |
| Maryland  |         | U.S.A.   |        | Baltimore  |                          | Md.  |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Towson  |         | St. Joseph Hospital  |        | HOUSEWIFE  |                          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Maryland  |         | BALTO  |        | Baltimore  |                          | 115 Riverside Rd.  |  |
| 14. FATHER'S NAME   |         | First  | Middle | Last   | 15. MOTHER'S MAIDEN NAME |  | First Middle Last                            |
| JOHN KALAL  |         |  |        |  | BARBARA SVEK             |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |         | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT  |                          | Address  |  |
| NO  |         |  |        | PAUL PAZOUREK  |                          | ABOVE  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |        |  |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |         |  |        |  |                          |  |  |
| IMMEDIATE CAUSE (a) Acute Myocardial Infarction   |         |  |        |  |                          |  |  |
| 410.9 DUE TO, OR AS A CONSEQUENCE OF  |         |  |        |  |                          |  |  |
| (b) Arteriosclerotic Cardiovascular disease   |         |  |        |  |                          |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |        |  |                          |  |  |
| (c)   |         |  |        |  |                          |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |        |  |                          |  |  |
| Minimal Pulmonary Edema   |         |  |        |  |                          |  |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                          | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                          |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                          |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 1/28, 1968, to 2/18, 1968, that (X) (we) last saw the deceased alive on 2/18, 1968, and that in (NY) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. |         |  |        |  |                          |  |  |
| 22b. SIGNATURE Samuel Lee   |         |  |        |  |                          | 22c. DATE SIGNED 2/18/68   |  |
| 22d. PHYSICIAN'S NAME (Type) Samuel Lee, M.D.   |         |  |        |  |                          | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |                          | 23d. LOCATION (City or Town) (County) (State)  |  |
| BURIAL  |         | 2/22/68  |        | SACRED HEART   |                          | BALTO. MD.   |  |
| 24. FUNERAL DIRECTOR J.G. CONNELLY SONS   |         |  |        | ADDRESS 300 MALE   |                          | 25a. REC'D BY REGISTRAR DATE FEB 21 1968   |  |
|   |         |  |        |  |                          | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |

02303

02303

02303

02303



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| <div style="text-align: center;"> <b>02310</b><br/> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</b><br/> <b>CERTIFICATE OF DEATH</b> </div> <div style="text-align: right;">02298</div>   |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>ELEANOR RILEY PECK</b>  |  |   |  | 2a. DATE OF DEATH<br><b>FEBRUARY 15, 1968</b>   |  |   |  | 2b. HOUR<br><b>M</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>OCT. 6, 1897</b>   |  | 6. AGE (In years lost birthday)<br><b>70</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                            |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b> Md.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>204 E. JOPPA RD.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>PRESIDENT</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SAW MFG.</b>  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. CITY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>TOWSON</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>204 E. JOPPA RD.</b>                    |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>ROBERT OLIVER MATTHEWS</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>ROSA M. DAVIS</b>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>219-22-6994</b>  |  | 17. INFORMANT Address<br><b>MR. GWYNN PECK 322 WORTHINGTON RD.</b>  |  |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>minutes</b><br><b>4129</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> <b>years</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction(s)</b> <b>years</b> |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                            |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |  | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January, 1967</b> , to <b>2/15, 1968</b> , that (I) (we) last saw the deceased alive on <b>1/23, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James R. Karns MD</b>   |  |   |  | 22c. DATE SIGNED<br><b>2/16/68</b>  |  |   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>DR. JAMES R. KARNS</b>            |  |  |  |
| 22e. ADDRESS<br><b>800 CATHEDRAL ST. BALTO., MD</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>2-19-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DULANEY VALLEY</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>COCKEYSVILLE, MD.</b>                       |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>MITCHELL-WIEDEFELD HOME INC.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 21 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>                                     |  |  |  |  |  |
| 25c. ADDRESS<br><b>6500 YORK ROAD BALTIMORE, MD. 21212</b>   |  |   |  |   |  |   |  |  |  |  |  |

03310

03310

03310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |   |                                   |                             |                             |  |
|---|--|--|--|---|--|---|--|---|-----------------------------------|-----------------------------|-----------------------------|--|
| 02311   |  |  |  |   |  | 02291   |  |   |                                   |                             |                             |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Sadye Elizabeth Pennington  |  |  |  |   |  | 2a. DATE OF DEATH Month Day Year<br>2 26 68   |  |   | 2b. HOUR<br>2:45 PM               |                             |                             |  |
| 3. SEX<br>Female  |  | 4. RACE<br>Cau.  |  | 5. DATE OF BIRTH<br>9-18-88   |  |   | 6. AGE (In years lost birthday)<br>79 YRS. |   | IF UNDER 1 YEAR MONTHS DAYS       |                             | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Baltimore Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |                                   |                             |                             |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore Md.  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Baltimore Medical Center |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br>Housewife |  |   | 12b. KIND OF BUSINESS OR INDUSTRY |                             |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Balto   |  | 13c. CITY OR TOWN<br>Md.  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  | 13e. STREET AND NUMBER<br>2900 Westfield Ave  |                                   |                             |                             |  |
| 14. FATHER'S NAME First Middle Last<br>John Patterson (dec)   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Ella J. <del>Paterson</del> Varnes  |  |   |  |   |                                   |                             |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br>No  |  | 16b. SOCIAL SECURITY No.<br>216-10-6582A   |  | 17. INFORMANT<br>Mrs. Alberta Coleman   |  | Address (same as patient's)   |  |   |                                   |                             |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u><br>203x<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>MULTIPLE MYELOMATOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>203x<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br>3 months |  |  |  |   |  |   |  |   |                                   |                             |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |   |                                   |                             |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                   |                             |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |                                   |                             |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                     |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |                                   | State                       |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/27</u> , 19 <u>67</u> , to <u>2/26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                 |  |  |  |   |  |   |  |   |                                   |                             |                             |  |
| 22b. SIGNATURE<br>Duncan D. McGhie  |  |  |  |   |  | DEGREE  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |                                   | 22c. DATE SIGNED<br>2/26/68 |                             |  |
| 22d. PHYSICIAN'S NAME (Type)<br>DUNCAN MCGHIE   |  |  |  |   |  | 22e. ADDRESS<br>616, E 34th ST. BALTIMORE Zone 18   |  |   |                                   |                             |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>2/29/68.  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Bethel Cemetery   |  | 23d. LOCATION (City or Town)<br>Madonna, Md.  |  | (County)  |                                   | (State)                     |                             |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Balto. Md. 21214  |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 27 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |                                   |                             |                             |  |

WESTERN DISTRICT

James O. Dwyer  
Dwight Dwyer

20/05/21 X

21. 34" 21. 34" 21. 34"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|-----------------------------|--|--|--|---------------------|--|--|--|---------------------------------------|--|--|--|--|--|--|--|
| 02312   |  |  |  |   |  |  |  |   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                  |  |  |  |   |  |  |  |                             |  |  |  | 02300               |  |  |  |                                       |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>EDWIN H. PERKINS  |  |  |  |   |  |  |  |   |  |  |  | 2a. DATE OF DEATH Month Day Year<br>February 26 1968   |  |  |  |   |  |  |  |                             |  |  |  | 2b. HOUR<br>6:30P M |  |  |  |                                       |  |  |  |  |  |  |  |
| 3. SEX<br>Male  |  |  |  | 4. RACE<br>White  |  |  |  | 5. DATE OF BIRTH<br>6/18/1892   |  |  |  | 6. AGE (In years last birthday)<br>75 YRS.   |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                           |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Joseph Hospital |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>RETIRED  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |  |  | 13b. COUNTY<br>Baltimore  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br>6111 Marietta Avenue        |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>JOHN H. PERKINS  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>ELLEN LONG  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-24-4892   |  |  |  | 17. INFORMANT<br>WIFE   |  |  |  | Address<br>Same  |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis, liver</u><br>197.8<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1567</u><br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>Acute tracheo-bronchitis</u> |  |  |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                        |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 22a. I certify that <u>10</u> (this hospital) attended the deceased from <u>February 10, 1968</u> , to <u>February 26, 1968</u> , that <u>10</u> (we) last saw the deceased alive on <u>February 26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>10</u> (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  | 22b. SIGNATURE<br><u>Reynaldo Orjuela-Gomez, M.D.</u> |  |  |  |                             |  |  |  |                     |  |  |  | 22c. DATE SIGNED<br>February 27, 1968 |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Reynaldo Orjuela-Gomez, M.D.  |  |  |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |  |  |  |   |  |  |  |  |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  |  |  | 23b. DATE<br>2/29/68  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LOUON PR.   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>BALD MD                                     |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>PAHEEMANN   |  |  |  | ADDRESS<br>6067 HARFORD RD  |  |  |  | 25a. REC'D BY REGISTRAR<br>MAR 4 1968   |  |  |  | 25b. REGISTRAR SIGNATURE   |  |  |  |   |  |  |  |                             |  |  |  |                     |  |  |  |                                       |  |  |  |  |  |  |  |

00000

OFFICE OF THE

00000

RECEIVED  
JAN 14 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle  |  | Last   |  | 2a. DATE OF DEATH<br>Month Day Year                                  |  | 2b. HOUR                                     |
| William   |  | H.   |  | PERRY   |  |  |  | February 26, 1968  |  | 7:40a  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |
| Male  |  | White  |  | April 30, 1930  |  | 37 YRS.  |  | MONTHS DAYS  |  | HOURS MIN.                                   |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |  |
| Maryland  |  | U.S.A.   |  |   |  | Baltimore, Md.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)       |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| Towson  |  | ST. JOSEPH HOSPITAL  |  |   |  | Auto Salesman - Al Packard   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |
| Maryland  |  | Baltimore  |  | Perry Hall  |  |  |  | 4347 Chapel Rd.  |  |  |
| 14. FATHER'S NAME   |  | First  |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME   |  | First Middle Last                            |
| William   |  | H.   |  | Perry   |  |  |  | Mavis M.   |  | ?  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (Wife)  |  | Address  |  | Perry Hall, Md.  |  |  |
| Yes   |  | 212-30-4866  |  | Mrs. Margorie J. Perry  |  | 4347 Chapel Rd.  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u><br>4120 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic and hypertensive cardiovascular disease</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>443X  |  |  |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   |  | 21f. LOCATION  |  | Street or R.F.D. No. City or Town County State                       |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 2/26/1968, to 2/26/1968, that (X) (we) last saw the deceased alive on 2/26/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Lawrence F. Misanik</i>  |  |  |  |   |  |  |  | 22c. DATE SIGNED<br>February 26, 1968                                |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | Lawrence F. Misanik, M.D.  |  |   |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |
| Burial  |  | 3/1/68   |  | Moreland Memorial Cemetery  |  | Baltimore, Md.   |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>John J. Duda, 2029 Hudson St. Balto. Md.  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 29 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                   |  |  |

02301

02313

February 20, 1968

Dear Sir:

I am writing to you regarding the matter of the

contract for the construction of the new building

at the site of the old building.

I am enclosing herewith a copy of the contract

for your review.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

I am sure that you will find it satisfactory.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |   |  |  |   |   |   |  |                                |
|---|--|---|---|---|--|--|---|---|---|--|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |  |  |   |   |   |  |                                |
| CERTIFICATE OF DEATH  |  |   |   |   |  |  |   |   |   |  |                                |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>CLARA  |   | Middle<br>R.  |  | Last<br>PETREY   |   | 2a. DATE OF DEATH<br>2 Month 21 Day 68 Year                                 |   |  | 2b. HOUR<br>11:15 P            |
| 3. SEX<br>Female  |  | 4. RACE<br>Cau.   |   | 5. DATE OF BIRTH<br>May 17, 1899  |  |  | 6. AGE (In years<br>lost birthday)<br>68 YRS. |   | IF UNDER 1 YEAR<br>MONTHS DAYS                      |  | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Washington, D. C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |   |   |   |  |                                |
| 10. CITY OR TOWN OF DEATH<br>Towson, Maryland   |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Greater Balto. Med. Center |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Secretary                                |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>U.S. Gov't. |  |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland  |  | 13b. COUNTY<br>BALTO  |   | 13c. CITY OR TOWN<br>Baltimore  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET AND NUMBER<br>87 Yorkway  |   |  |                                |
| 14. FATHER'S NAME First Middle Last<br>Robert Studds  |  |   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Theresa Custin  |  |  |   |   |   |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) no  |  | 16b. SOCIAL SECURITY NO.<br>578-12-6776   |   | 17. INFORMANT<br>Richard H. Petrey, Son, 2466 Keyway<br>Baltimore, Md.  |  |  |   |   |   |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Severe lactic acidosis<br>5701<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Acute pyelonephritis<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost.<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Diabetes mellitus |  |   |   |   |  |  |   |   |   |  |                                |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? Yes |   |  |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |   |   |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |  |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/21, 1968, to 2/21, 1968, that (I) (we) lost<br>saw the deceased alive on 2/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |   |   |   |  |                                |
| 22b. SIGNATURE<br>John E. Adams   |  |   |   |   |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>Feb. 22, 1968   |   |  |                                |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>JOHN E. ADAMS, M.D.  |  |   |   |   |  | 22e. ADDRESS<br>Greater Baltimore Medical Center   |   |   |   |  |                                |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>2/26/68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National Cemetery   |  |  |   | 23d. LOCATION (City or Town) (County) (State)<br>Arlington Virginia         |   |  |                                |
| 24. FUNERAL DIRECTOR<br>Joseph Gawler's Sons, Inc. Washington, D. C.  |  |   |   |   |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 1 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Jaffe                              |   |  |                                |

05316

05316

OFFICE OF THE

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

1962

*John S. Allen*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</b><br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |  |   |  |  |   |  |  |   |  |  |  |  |   |  |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>David  |  |  | Middle<br>Park  |  |  | Last<br>Petrikin  |  |  | 2a. DATE OF DEATH<br>Month <u>2</u> Day <u>27</u> Year <u>1968</u> |  |   | 2b. HOUR<br><u>1</u> <u>AM</u>                               |  |  |
| 3. SEX<br><u>Male</u>   |  |  | 4. RACE<br><u>Whiten</u>  |  |  | 5. DATE OF BIRTH<br><u>8-1-1876</u>   |  |  | 6. AGE (In years lost birthday)<br><u>91</u> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS <u>  </u> DAYS <u>  </u>                 |  | IF UNDER 24 HRS.<br>HOURS <u>  </u> MIN <u>  </u> |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><u>Johnstown Pa.</u>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><u>Baltimore</u>  |  |  | Md.  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Linthigh</u>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>7435 Kenlea Ave</u>    |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><u>Roller</u>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>Bethlehem C</u>   |  |  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><u>Md.</u>   |  |  | 13b. COUNTY<br><u>Balto.</u>  |  |  | 13c. CITY OR TOWN<br><u>Linthigh</u>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><u>7435 Kenlea Avenue</u>                |  |   |  |  |  |
| 14. FATHER'S NAME<br>First <u>Henry</u> Middle <u>  </u> Last <u>Petrikin</u>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First <u>Lucia</u> Middle <u>  </u> Last <u>Knowlton</u>                      |  |  |   |  |  |   |  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.<br><u>196-07-9434</u>  |  |  | 17. INFORMANT<br><u>Mrs Lucille Slavik</u>  |  |  | Address<br><u>7435 Kenlea Avenue 21236</u>  |  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u><br><u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |   |  |  |   |  |  |   |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs</u> |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>4200</u>  |  |  |   |  |  |   |  |  |   |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>19</u><br>P.M. <u>  </u> |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  |  | 21f. LOCATION Street or R.F.D. No. <u>  </u> City or Town <u>  </u> County <u>  </u> State <u>  </u>  |  |  |   |  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>62</u> , to <u>2/27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Conrad L. Richter</u> DEGREE <u>  </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |  |  |   |  |  |   |  |  |  |  |   | 22c. DATE SIGNED<br><u>2/27/68</u>                           |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>Conrad L. Richter</u>  |  |  |   |  |  |   |  |  |   |  |  |  |  |   | 22e. ADDRESS<br><u>3128 Hayford Rd Beltsville, Md</u>        |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |  | 23b. DATE<br><u>2-29-1968</u>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Grandview Cemetery</u>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Johnston</u> <u>  </u> <u>Penna.</u>        |  |  |  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Lassahn Funeral Home 7401 Belair Road</u> ADDRESS <u>  </u> <u>36</u>  |  |  |   |  |  |   |  |  |   |  |  |  |  |   |  |  |  |
| 25a. REC'D BY REGISTRAR<br><u>DATE MAR 4 1968</u>   |  |  |   |  |  |   |  |  |   |  |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. [Signature]</u>  |  |  |

02310

13309

STATE OF TEXAS



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02316

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02304

|   |         |                  |   |                                |  |   |  |  |   |  |   |  |
|---|---------|------------------|---|--------------------------------|--|---|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First Middle Last   |                                |  | 2a. DATE KNOWN<br>OF ESTI.<br>DEATH MATED <input checked="" type="checkbox"/> 2/27  |  |  | 2b. HOUR<br>19 68 6:30  |  |   |  |
| MARY  |         |                  | CATHERINE   |                                |  | PHILLIPS  |  |  |   |  |   |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years<br>last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS |  | IF UNDER 24 HRS<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |   |  | 2d. HOUR  |  |
| female  | white   | Mar. 26, 1934    | 33 YRS  |                                |  |   |  | February 27                                |   |  | 8 A M   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                                |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH  |  |   |  |
| Maryland  |         |                  | U.S.A.  |                                |  |   |  |  | Baltimore Md.   |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                                |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |   |  |
| Dundalk   |         |                  | 4011 St. Monica Drive   |                                |  | At home   |  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         |                  | 13b. COUNTY   |                                |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| Maryland  |         |                  | Baltimore   |                                |  |   |  |  | 4011 St. Monica Drive   |  |   |  |
| 14. FATHER'S NAME   |         |                  | 15. MOTHER'S MAIDEN NAME  |                                |  |   |  |  |   |  |   |  |
| First Middle Last   |         |                  | First Middle Last   |                                |  |   |  |  |   |  |   |  |
| James   |         |                  | L. Morrissey  |                                |  | Edna Earl Fields  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |                  | 16b. SOCIAL SECURITY NO.  |                                |  | 17. INFORMANT   |  |  | ADDRESS   |  |   |  |
| No  |         |                  |   |                                |  | Paul F. Morrissey   |  |  | 1304 First Road. 21220  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fatty Alteration of Liver</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.  |         |                  |   |                                |  |   |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |         |                  |   |                                |  |   |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |                                |  |   |  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.                          |                                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |         |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |                                |  | 21f. LOCATION Street or R.F.D. No.  |  |  | City or Town  |  | County State                                    |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  |   |                                |  |   |  |  |   |  |   |  |
| ACTUAL<br>SIGNATURE   |         |                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                                 |                                |  |   |  |  | 22b. DATE SIGNED  |  |   |  |
| EXAMINER'S<br>NAME (Type)   |         |                  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |                                |  |   |  |  | 2.27.68   |  |   |  |
| Werner U. Spitz, M.D.   |         |                  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                |                                |  |   |  |  | ADDRESS(Street, city, town, or county)  |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         |                  | 23b. DATE   |                                |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City or Town) (County) (State)   |  |   |  |
| Burial  |         |                  | 3/2/68  |                                |  | Meadow Ridge  |  |  | Dorsey, Md.   |  |   |  |
| 24. FUNERAL DIRECTOR  |         |                  |   |                                |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                      |  |
| Ulrich Funeral Home Dundalk, Md.  |         |                  |   |                                |  |   |  |  | MAR 5 1968  |  | Charles Judge                                   |  |

03318

03304

Mar 5 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |  |  |   |                        |  |
|---|--|--|---|---|--|--|--|---|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |  |  |   |                        |  |
| CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |   |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last   |   |  | 2a. DATE OF DEATH<br>Month Day Year  |  | 2b. HOUR<br>P. M.                           |                        |  |
| Richa rd  |  |  | Pinkney   |   |  | February 6 1968  |  | 9:55 P.                                     |                        |  |
| 3. SEX  |  | 4. RACE  |   | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>lost birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS              |                        |  |
| male  |  | Negro  |   | 1876/2-9-1879   |  | 98 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN               |                        |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  | Md.   |                        |  |
| Md.   |  | U. S.  |   |   |  | Baltimore  |  |   |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY        |                        |  |
| Catonsville   |  |  | SPRING GROVE STATE HOSP.  |   |  | laborer  |  |   |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  |  | 13b. COUNTY   |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER |  |
| Md.   |  |  | Pr. Geo.  |   | Cedar Hgts.  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |   | 904 - 64th Avenue      |  |
| 14. FATHER'S NAME<br>First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                   |   |  |  |  |   |                        |  |
| Robert Pinkney  |  |  | Laura Brooks  |   |  |  |  |   |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address  |  |  |   |                        |  |
|   |  |  | 219-54-3272   |   | Records: SPRING GROVE STATE HOSPITAL   |  |  |   |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction, Acute, death, 3 days<br>4100 DUE TO, OR AS A CONSEQUENCE OF vascular ht. dis. with Atrial Fibrillation<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 4201 (b) Arteriosclerotic, Hypertensive, cardio- 3 years.<br>DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, generalized, senile 20 yrs. |  |  |   |   |  |  |  |   |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) calcified.<br>Arteriolar nephrosclerosis with azotemia; Subdural Hematoma, old,  |  |  |   |   |  |  |  |   |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?              |   |                        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                         |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |                        |  |
| 22a. I certify that (he) (this hospital) attended the deceased from Oct. 27, 1965, to Feb. 6, 1968, that (he) (we) last saw the deceased alive on Feb. 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |   |   |  |  |  |   |                        |  |
| 22b. SIGNATURE<br>Anthony J. Young, M.D.  |  |  |   |   |  | DEGREE ATTENDING<br>PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2-7-68                  |                        |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Anthony J. Young, M.D.   |  |  |   |   |  | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228   |  |   |                        |  |
| 23a. BURIAL, CREMATION<br>REMOVAL (Specify)   |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |                        |  |
| Burial  |  | 2-14-68  |   | Brooks Church Cem.  |  | Nottingham Pr. Geo. Md.  |  |   |                        |  |
| 24. FUNERAL DIRECTOR<br>Martell Adams   |  |  |   | ADDRESS<br>Aguasca, Md.   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 16 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |                        |  |

Res. 740.4 Kirby Road  
Clinton, Md.  
P.G. Co.

re Mrs. Moser

3/13/68 as

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02318

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02346

|   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Virginia</b>   |  |  | First <b>B.</b> Middle <b>Poisal</b> Last  |  |  | 2a. DATE OF DEATH<br>Month <b>Feb</b> Day <b>22</b> Year <b>1968</b>  |  |  | 2b. HOUR<br><b>9:45p</b> M  |  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>March 30, 1916</b>   |  |  | 6. AGE (In years last birthday)<br><b>51</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.            |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Balto. Md</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Shangri-La Nursing Home</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Secretary</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Real Estate</b>   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Balto.</b>   |  |  | 13c. CITY OR TOWN<br><b>Balto</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>3401 Rockdale Court</b> |  |  |
| 14. FATHER'S NAME<br><b>Clarence</b>  |  |  | First <b>Billmyer</b> Middle <b>Edith</b> Last <b>Bain</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br><b>George D. Poisal</b>   |  |  | First <b>Edith</b> Middle <b>Bain</b> Last  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>212-03-3233</b>   |  |  | 17. INFORMANT<br><b>George D. Poisal</b>  |  |  | Address<br><b>3401 Rockdale Court<br/>Balto. Md 21207</b>                                       |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>174x</b> IMMEDIATE CAUSE (a) <b>C.A. of Breast</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized Metastases</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>170x</b>  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                   |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-2-</b> , 19 <b>68</b> , to <b>2-22-</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-22-</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Cesar Valle Cervero</b>  |  |  | DEGREE<br><b>MD</b>  |  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  |  | 22c. DATE SIGNED<br><b>2-24-68</b>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Cesar Valle Cervero</b>  |  |  | 22e. ADDRESS<br><b>8629 Liberty Rd Randallstown, Md 21133</b>  |  |  |   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>2/26/68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Memorial</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Liberty Rd Carroll Co. Md</b>               |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>George Byers</b>   |  |  | ADDRESS<br><b>8728 Liberty Rd Randallstown, Md</b>   |  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 27 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |  |  |

05318

REMARKS

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02319</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02307</div>  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>GEORGE POPP</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>11</b> Year <b>1968</b>                       |  |   | 2b. <b>HQM</b><br>Time <b>2:45 M</b>             |  |  |
| 3. SEX<br><b>M</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br><b>February 17 1873</b>   |  |   | 6. AGE (In years last birthday)<br><b>94</b>                         |   | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>       |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto</b>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Glen Arm Rd.</b>   |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Ret. Guard</b>                    |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto City</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md</b>   |  | 13b. COUNTY<br><b>Balto</b>  |  | 13c. CITY OR TOWN<br><b>Glen Arm Rd.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Glen Arm Rd.</b>   |  |  |  |
| 14. FATHER'S NAME<br>First <b>John</b> Middle <b>Popp</b> Last <b>Popp</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Rachel</b> Middle <b>Green</b> Last <b>Green</b>   |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, not (unknown) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service) <b>217-48-1628</b> |  | 17. INFORMANT<br><b>Family Records</b>  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4109 Coronary occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>4201</b>                             |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                     |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Henry L. McCorkle M.D.</b>  |  |  |  |   |  | DEGREE<br><b>M.D.</b>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>2-13-68</b>                 |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Henry L. McCorkle M.D.</b>  |  |  |  |   |  | 22e. ADDRESS<br><b>Jacksonville, Maryland</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>2-13-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto Co Md.</b> |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>C.F. EVANS &amp; SON 8802 Harford road</b>  |  |  |  |   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 15 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

02314

02314

SEP 22 1968

RECEIVED

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

SEP 22 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |  |  |  |  |                                   |   |
|--|--|---|--|--|--|--|--|-----------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |  |  |  |                                   |   |
| CERTIFICATE OF DEATH   |  |   |  |  |  |  |  |                                   |   |
| 1. DECEASED-NAME (Type or print)   |  |   | First Middle Last  |  |  | 2a. DATE OF DEATH  |  | 2b. HOUR                          |   |
| Mary Teresa Pospisil   |  |   |  |  |  | February 10 1968   |  | 9:15 AM                           |   |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS       |   |
| female   |  | white   |  | June 28, 1884  |  | 83 YRS.  |  |                                   |   |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                                   |   |
| Baltimore, Md.   |  | U.S.A.  |  |  |  | Baltimore  |  | Md.                               |   |
| 10. CITY OR TOWN OF DEATH  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| Bowleys Quarters   |  |   | Box 537, Rt. 15, Bay Dr.   |  |  | housewife  |  | none                              |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |   | 13b. COUNTY  |  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |   |
| Md.  |  |   | Baltimore  |  |  |  |  | Box 537, Rt. 15, Bay Drive        |   |
| 14. FATHER'S NAME  |  |   | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |                                   |   |
| John Priol   |  |   | Frences Velnovsky  |  |  |  |  |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT  |  | Address                           |   |
| no   |  |   | 213-48-0495  |  |  | Albert Pospisil, above, son  |  |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>?</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.                  |  |   |  |  |  |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>FEB 1 1968</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4221</u>  |  |   |  |  |  |  |  |                                   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                              |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                                   |   |
| NONE   |  | NONE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | NONE   |  |                                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |  |  |  |                                   |   |
|  |  | NONE  |  | NONE   |  |  |  |                                   |   |
| 21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work or while <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) |  | 21f. LOCATION  |  | City or Town   |  | County State                      |   |
| NONE   |  | NONE  |  | NONE   |  |  |  |                                   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB 2</u> , 19 <u>68</u> , to <u>FEB 10</u> , 19 <u>68</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>FEB 7</u> , 19 <u>68</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did) ( <del>did not</del> ) view the body after death. |  |   |  |  |  |  |  |                                   |   |
| 22b. SIGNATURE <u>E. A. SCHIMUNEK</u> M.D. DEGREE  |  |   |  |  |  | 22c. DATE SIGNED   |  |                                   |   |
| 22d. PHYSICIAN'S NAME (Type) Dr. E. A. Schimunek   |  |   |  |  |  | 22e. ADDRESS   |  |                                   |   |
|  |  |   |  |  |  | 842 S. EAST AVE BALTO. MD 21224  |  |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |   |
| Burial   |  | 2/13/68   |  | Holy Redeemer Cemetery   |  | Baltimore, Md.   |  |                                   |   |
| 24. FUNERAL DIRECTOR   |  |   |  |  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE        |   |
| Schimunek Funeral Home<br>3331 Brehms Lane #13   |  |   |  |  |  | DATE FEB 14 1968   |  |                                   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6, Film G398 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3/4/68 ap

02321

# CERTIFICATE OF DEATH

02309

|   |  |   |                |   |   |  |   |   |                                      |         |                                |
|---|--|---|----------------|---|---|--|---|---|--------------------------------------|---------|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print)   |  | First JOHN  | Middle STANLEY | Last  | 2a. DATE OF DEATH   |  |   | 2b. HOUR                                    |                                      |         |                                |
|   |  | Stanley#####I##   |                |   | Probst  |  |   | Month 2                                     | Day 25                               | Year 68 | 9:35p M                        |
| 3. SEX  |  | 4. RACE   |                | 5. DATE OF BIRTH  |   |  | 6. AGE (In years<br>lost birthday)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS       |         | IF UNDER 24 HRS.<br>HOURS MIN. |
| Male  |  | White   |                | 6/26/1896   |   |  | 72 7 1/2 YRS.   |   |                                      |         |                                |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |                | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |   |   |                                      |         |                                |
| Illinois  |  | U. S. A.  |                |   |   | Baltimore Md.  |   |   |                                      |         |                                |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                |   |   | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |   |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY |         |                                |
| Baltimore   |  | Greater Balto., Med. Center   |                |   |   | Adv. Owner   |   |   | ADV.                                 |         |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  | 13b. COUNTY   |                | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |   | 13e. STREET AND NUMBER                      |                                      |         |                                |
| Md.   |  | Baltimore   |                | Ruxton  |   |  |   | 1604 Ruxton Ct.                             |                                      |         |                                |
| 14. FATHER'S NAME   |  | First   | Middle         | Last  | 15. MOTHER'S MAIDEN NAME  |  | First   | Middle                                      | Last                                 |         |                                |
|   |  | Nicholas  |                | Prodst  | Joanna  |  |   |   | Gleason                              |         |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)  |  | 16b. SOCIAL SECURITY NO.  |                | 17. INFORMANT   |   | Address  |   |   |                                      |         |                                |
| Yes   |  | W. W. One   |                | Mrs. Helen Louise Probst, Same as #13   |   |  |   |   |                                      |         |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br><u>4129</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |                |   |   |  |   |   |                                      |         |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |                |   |   |  |   |   |                                      |         |                                |
| MEDICAL CERTIFICATION   |  |   |                |   |   |  |   |   |                                      |         |                                |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |                |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? Yes |   |                                      |         |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |                |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |  |   |   |                                      |         |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |                |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |   |   |                                      |         |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/18</u> , 19 <u>68</u> , to <u>2/25</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>2/25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                            |  |   |                |   |   |  |   |   |                                      |         |                                |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED  |                |   |   |  |   |   |                                      |         |                                |
|   |  | 22d. PHYSICIAN'S<br>NAME (Type) R. Breiteneker, M.D.                            |                |   |   |  | 22e. ADDRESS 6701 N. Charles Street   |   |                                      |         |                                |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |                | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |   |   |                                      |         |                                |
| Burial  |  | Feb. 28, 1968   |                | Baltimore National  |   | Baltimore, Maryland  |   |   |                                      |         |                                |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, 1050 York Road<br>Towson, Md. 21204   |  |   |                |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 29 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |                                      |         |                                |

1950

1950

1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>02322</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>02319</span> </div> <div style="text-align: center;">             DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201<br/> <b>CERTIFICATE OF DEATH</b> </div>   |  |  |   |  |  |   |  |  |   |  |  |  |  |                                |                            |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--------------------------------|----------------------------|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  | First Gladys  |  |  | Middle A.   |  |  | Last PUKALL   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br>February 13, 1968 |  |                                | 2b. HOUR<br>8:05AM         |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>March 26, 1914  |  |  | 6. AGE (In years last birthday)<br>53 YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                           |  | IF UNDER 24 HRS.<br>HOURS MIN. |                            |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Pennsylvania  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore, Md.  |  |  |  |  |                                |                            |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>ST. JOSEPH HOSPITAL |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Homemaker  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home  |  |  |  |  |                                |                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |  | 13b. COUNTY<br>BALTO  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |  |  | 13e. STREET AND NUMBER<br>3116 Willoughby Rd.            |  |                                |                            |  |  |
| 14. FATHER'S NAME<br>First Samuel  |  |  | Middle Schubert   |  |  | Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Mary Ellen  |  |  | Middle Hainworth   |  |                                | Last                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |  | (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT<br>William A. Pukall  |  |  | Address<br>Same  |  |                                |                            |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertension</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |   |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |                                |                            |  |  |
|  |  |  |   |  |  |   |  |  |   |  |  |  |  |                                |                            |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |  |  |   |  |  |   |  |  |  |  |                                |                            |  |  |
| 331X   |  |  |   |  |  |   |  |  |   |  |  |  |  |                                |                            |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |  |                                |                            |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |  |  |                                |                            |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                        |  |  | 21f. LOCATION Street or R.F.D. No.  |  |  | City or Town  |  |  | County State   |  |                                |                            |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital), attended the deceased from <u>2/12/</u> , 19 <u>68</u> , to <u>2/13/</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2/13/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |   |  |  |  |  |                                |                            |  |  |
| 22b. SIGNATURE<br>Gualberto Gokim, Jr., M.D. DEGREE  |  |  |   |  |  |   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  | 22c. DATE SIGNED<br>February 13, 1968                    |  |                                |                            |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Gualberto G. Gokim Jr.   |  |  |   |  |  |   |  |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md. 21204  |  |  |  |  |                                |                            |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  |  | 23b. DATE<br>2-16-1968  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Garden of Faith   |  |  | 23d. LOCATION (City or Town)<br>Baltimore   |  |  | (County) (State)<br>Md                                   |  |                                |                            |  |  |
| 24. FUNERAL DIRECTOR<br>Charles T. Evans, Jr.  |  |  |   |  |  |   |  |  | ADDRESS<br>8802 Hartford Rd   |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 14 1968              |  |                                | 25b. REGISTRAR'S SIGNATURE |  |  |

05310

STATE OF TEXAS

03330

0000

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |                                     |   |  |  |   |  |                             |  |
|---|--|--|---|--|-------------------------------------|---|--|--|---|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |                                     |   |  |  |   |  |                             |  |
| CERTIFICATE OF DEATH  |  |  |   |  |                                     |   |  |  |   |  |                             |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>MARY M. RADWITCH</b>   |  |  |   |  |                                     | 2a. DATE OF DEATH Month Day Year<br><b>FEB 5 68</b>                                     |  |  | 2b. HOUR<br><b>3:00 P.M.</b>                    |  |                             |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH<br><b>1/10/92</b>   |                                     |   | 6. AGE (In years lost birthday)<br><b>76</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.          |  | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH<br><b>BALTO</b> Md.  |  |  |   |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7001 DUNMANWAY</b> |  |                                     | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>DUNDALK</b> |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>7001 DUNMANWAY</b> |  |                             |  |
| 14. FATHER'S NAME First Middle Last<br><b>WILLIAM STUBBS</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>?</b>   |                                     |   |  |  |   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>-</b>  |  | 17. INFORMANT<br><b>ANN ZINKAND</b> |   |  | Address<br><b>ABOVE</b>  |   |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>197.8</b> IMMEDIATE CAUSE (a) <b>OCA of Liver</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1561</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>Diabetes Mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <b>Myasthenia Gravis</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 mos</b><br><b>2 yrs</b><br><b>5 yrs</b> |  |  |   |  |                                     |   |  |  |   |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>A-S-C-V Disease</b>   |  |  |   |  |                                     |   |  |  |   |  |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |                                     | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                     |   |  |  |   |  |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                     |   |  |  |   |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 5</b> , 19 <b>68</b> , to <b>Feb 5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Feb 5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |                                     |   |  |  |   |  |                             |  |
| 22b. SIGNATURE<br><b>M.B. Davis MD</b>  |  |  |   |  |                                     | 22c. DATE SIGNED<br><b>2/16/68</b>  |  |  |   |  |                             |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>M.B. DAVIS MD</b>  |  | 22e. ADDRESS<br><b>6800 MORNING GLORY LANE - DUNDALK</b>                     |   |  |                                     |   |  |  |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2/18/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DAK LAWN</b>  |                                     |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                           |  |   |  |                             |  |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELLY SONS</b>   |  |  |   |  |                                     | ADDRESS<br><b>300 MACE</b>  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 8 1968</b>                         |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |                             |  |

0533

0531

0531



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |   |  |   |
|--|--|--|--|---|--|---|--|---|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |   |  |   |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |   |  |   |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>RUTH  |  | Middle<br>EVELYN  |  | Last<br>RAUSCH  |  | 2a. DATE OF DEATH<br>Month 2 Day 14 Year 68 |  | 2b. HOUR<br>12:45 <sup>PM</sup>                 |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>4-27-1892   |  | 6. AGE (In years<br>lost birthday)<br>75 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS              |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Baltimore  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |   |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Greater Balto. Medical Center |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)      |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY        |  |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>6501 Liberty Road |  |   |
| 14. FATHER'S NAME First Middle Last<br>Jacob Mehrling  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Jordan  |  |   |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO  |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br>Harry A. Rausch-6501 Liberty Road                                      |  |   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple pulmonary infarcts<br>450 X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>460 X Carcinoma, right breast  |  |  |  |   |  |   |  |   |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? YES                     |  |   |  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/6, 1968, to 2/14 19 68, that (I) (we) last saw the deceased alive on 2/14 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                      |  |  |  |   |  |   |  |   |  |   |
| 22b. SIGNATURE<br>Rudiger Breiteneker  |  |  |  |   |  |   |  | 22c. DATE SIGNED<br>2/14/68                 |  |   |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Rudiger Breiteneker, M. D.  |  | 22e. ADDRESS<br>Greater Baltimore Medical Center   |  |   |  |   |  |   |  |   |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>2-17-68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |   |  |   |
| 24. FUNERAL DIRECTOR<br>4600 Liberty Road<br>Eleanor H. H. H.  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 20 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |  |   |  |   |

10000

00000

RECEIVED

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000

10000



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02325

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02319

|  |                         |   |   |   |                                      |   |   |   |  |
|--|-------------------------|---|---|---|--------------------------------------|---|---|---|--|
| 1. DECEASED-NAME (Type or Print)<br><b>IRMA LOUISE RAY</b>   |                         |   | 2a. DATE KNOWN OF DEATH<br>Month <b>2</b> Day <b>25</b> Year <b>19 68</b> |   |                                      | 2b. HOUR<br><b>1:30</b>   |   |   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>3/29/34</b>  | 6. AGE (In years last birthday)<br><b>34</b> YRS.                         | IF UNDER 1 YEAR<br>MONTHS<br><b>0</b>   | IF UNDER 24 HRS.<br>DAYS<br><b>0</b> | IF UNDER 24 HRS.<br>HOURS<br><b>0</b>   | IF UNDER 24 HRS.<br>MIN.<br><b>0</b>  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Feb.</b> Day <b>25</b> Year <b>19 68</b> | 2d. HOUR<br><b>1:30</b>                          |
| 7a. BIRTHPLACE (State or foreign country)<br><b>VA.</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. COUNTY OF DEATH<br><b>Balto.</b>   |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>North Pt. Rd. Discount Liquors</b> |   |   |                                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>PAPER</b>                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |                         |   | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>313 Capital Ct.</b> |
| 14. FATHER'S NAME First Middle Last<br><b>ROBERT H. DONAWANT</b>   |                         |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>MARY HODEES</b>          |   |                                      |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                         |   | 16b. SOCIAL SECURITY NO.<br><b>—</b>                                      |   | 17. INFORMANT<br><b>JACOB RAY</b>    |   | ADDRESS<br><b>ABOVE</b>   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of the chest and back</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>965 X</b>  |                         |   |   |   |                                      |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |   |   |   |                                      |   |   |   |  |
| 19a. DATE OF OPERATION<br><b>2/28/68</b>   |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                         |   |                                      |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                        |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br><b>12:31 2 25 19 68</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Subject was shot several times</b>                                    |                                      |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>St.</b>                            |   | 21f. LOCATION Street or R.F.D. No.<br><b>North Pt. Rd.</b>  |                                      | City or Town<br><b>Balto.</b>   |   | County<br><b>Balto.</b>   | State<br><b>Md.</b>                              |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |   |   |                                      |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Edward F. Wilson</b>  |                         |   | M.D.<br><b>Edward F. Wilson, M.D.</b>                                     |   |                                      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED<br><b>Feb. 25, 1968</b>                                      |  |
| EXAMINER'S NAME (Type)   |                         |   | ADDRESS (Street, city, town, or county)                                   |   |                                      | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>2/28/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>   |                                      | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD</b>                       |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>J.E. CONNELL</b>  |                         |   |   | ADDRESS<br><b>300 MACE</b>  |                                      | 25a. REC'D BY REGISTRAR<br><b>Feb. 28 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>                            |  |

05381

05380

STATE OF  
NEW YORK

IN SENATE  
JANUARY 1, 1903

REPORT OF THE  
COMMISSIONER OF THE  
LAND OFFICE

FOR THE YEAR  
1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02326   |  |  |  |  |  |   |  |  |   | 02314                |  |   |  |  |                                       |                            |  |  |  |  |
|---|--|--|--|--|--|---|--|--|---|----------------------|--|---|--|--|---------------------------------------|----------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   | CERTIFICATE OF DEATH |  |   |  |  |                                       |                            |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br>CHARLES E   |  |  | Middle<br>READ  |  |  | Last<br>READ  |                      |  | 2a. DATE OF DEATH<br>Month 2 Day 5 Year 68  |  |  | 2b. HOUR<br>12 PM                     |                            |  |  |  |  |
| 3. SEX<br>M   |  |  | 4. RACE<br>W   |  |  | 5. DATE OF BIRTH<br>7-11-93   |  |  | 6. AGE (In years<br>last birthday)<br>74 YRS.   |                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS              |  |  | IF UNDER 24 HRS.<br>HOURS MIN         |                            |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MD  |  |  | 7b. CITIZEN, OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>BALTO. County Md.   |                      |  |   |  |  |                                       |                            |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonville   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Summit Hx. H. Elect. H. |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Electrician   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |                      |  |   |  |  |                                       |                            |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE MD.  |  |  | 13b. COUNTY<br>BALTO.  |  |  | 13c. CITY OR TOWN<br>BALTO.   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                      |  | 13e. STREET AND NUMBER<br>3225 Leeds Street |  |  |                                       |                            |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>William Read  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Unknown   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown) (If yes give war or dates of service)<br>WAS   |  |  |   |                      |  | 16b. SOCIAL SECURITY NO.<br>219-10-6040     |  |  | 17. INFORMANT<br>WIFE - Same as above |                            |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Carcinoma to Brain<br>DUE TO, OR AS A CONSEQUENCE OF Primary Site unknown<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. 1930<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>ASCVD |  |  |  |  |  |   |  |  |   |                      |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>? |  |                                       |                            |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |                      |  |   |  |  |                                       |                            |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |                      |  |   |  |  |                                       |                            |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |                      |  |   |  |  |                                       |                            |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-4-68, to 2-5-68, that (I) (we) last<br>saw the deceased alive on 2-4-1968 and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |   |                      |  |   | 22b. SIGNATURE<br>Earl Pass M.D.                     |  |                                       | 22c. DATE SIGNED<br>2-5-68 |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>EARL PASS, M.D.  |  |  | 22e. ADDRESS<br>4001 Welles Ave  |  |  | 22f. ADDRESS  |  |  |   |                      |  |   |  |  |                                       |                            |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>2-8-1968  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Balto. National   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore Md.                                  |                      |  |   |  |  |                                       |                            |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>G. Howard   |  |  | ADDRESS<br>Strong 3207 W. North Ave.,  |  |  | 25a. REC'D BY REGISTRAR<br>FEB 7 1968   |  |  | 25b. REGISTRAR'S SIGNATURE  |                      |  |   |  |  |                                       |                            |  |  |  |  |

03330

1831

DEPARTMENT OF STATE

OFFICE OF THE SECRETARY OF STATE

WASHINGTON, D. C.

January 1, 1918

TO THE SECRETARY OF STATE

FROM THE SECRETARY OF STATE

SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02327   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02315  |  |  |  |  |                             |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <i>Sophia Marie</i> <i>Reed</i>  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH <i>2</i> Month <i>19</i> Day <i>68</i> Year  |  |  |  |  |  |  |  |  |  | 2b. HOUR <i>11:30</i> AM                             |  |  |  |  |                             |  |  |  |  |
| 3. SEX <i>F.</i>  |  |  |  |  | 4. RACE <i>W.</i>  |  |  |  |  | 5. DATE OF BIRTH <i>2/22/1889</i>  |  |  |  |  | 6. AGE (In years last birthday) <i>78</i> YRS.   |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                          |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH <i>Baltimore</i> Md.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Parkville</i>  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3001 1/2 Moreland Ave.</i> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |  |  |  |  | 13b. COUNTY <i>Balto.</i>  |  |  |  |  | 13c. CITY OR TOWN <i>Parkville</i>   |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER <i>3001 1/2 Moreland Ave.</i> |  |  |  |  |                             |  |  |  |  |
| 14. FATHER'S NAME First <i>John</i> Middle <i>Trageser</i> Last <i>Trageser</i>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Petri</i> Last <i>Petri</i>                           |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO. <i>220-12-8914</i>  |  |  |  |  | 17. INFORMANT Address <i>Mrs. Margaret Matthaei same</i>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><i>4120</i> IMMEDIATE CAUSE (a) <i>arteriosclerotic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>with hypertension</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>1954</i>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>443X</i>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i> P.M.  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 26</i> , 19 <i>54</i> , to <i>26-19</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Feb 19</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 22b. SIGNATURE <i>E. J. Alessi</i> M.D.   |  |  |  |  | 22c. DATE SIGNED <i>2/20/68</i>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>E. J. Alessi</i> M.D.   |  |  |  |  | 22e. ADDRESS <i>6217 Harford Rd. Balto. Md.</i>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  |  |  |  | 23b. DATE <i>2/22/68</i>   |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <i>Balto. Md.</i>                              |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |
| 24. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md.</i>   |  |  |  |  | 25a. REC'D BY REGISTRAR <i>20 1968</i>   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |

MEDICAL CERTIFICATION

03534

03534

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "OFFICE" and "RECEIVED" are visible.]*

*[Vertical text on the right margin, likely bleed-through from the reverse side. Some words like "RECEIVED" and "OFFICE" are visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |                                   |  |  |
|---|--|--|--|--|---|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |                                   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |                                   |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH  |  | 2b. HOUR                          |  |  |
| John FRANK Remley   |  |  |  |  |   | Month Day Year   |  | 9:45 A M                          |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR MONTHS DAYS       |  |  |
| Male  |  | Cauc   |  | 2/9/1887   |   | 81 YRS.  |  |                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                                   |  |  |
| Md.   |  | U.S.A.   |  |  |   | Balto. Md.   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Balto. 21204  |  |  | G.B.M.C.   |  |   | Retired CIVIL ENG  |  | PA R.R.                           |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Md.   |  |  | Balto (12)   |  | Balto.  |  |  |                                   | 525 Register Ave                             |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |  |                                   |  |  |
| John FRANK Remley   |  |  | Elizabeth KLEISS   |  |   |  |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |                                   |  |  |
| No  |  |  | 717-07-9527  |  | Roberta B. Remley   |  | Above  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Arteriosclerotic cardiovascular disease   |  |  |  |  |   |  |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____  |  |  |  |  |   |  |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |  |   |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |  |                                   |  |  |
| 4221  |  |  |  |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES                     |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |  |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2.27, 1968, to 2.28, 1968, that (I) (we) last saw the deceased alive on 2.28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE Robert Bassiri   |  |  |  |  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED 2/28/68          |  |  |
| 22d. PHYSICIAN'S NAME (Type) BASSIRI  |  |  |  |  |   | 22e. ADDRESS GBMC  |  |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |  |  |
| Rem. Burial   |  | 3/1/1968   |  | St. James Episcopal  |   | Bristol, Pa.   |  |                                   |  |  |
| 24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.  |  |  |  |  |   | 25a. REC'D BY REGISTRAR MAR 1 1968   |  | 25b. REGISTRAR'S SIGNATURE        |  |  |

RESO

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1-2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2-M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02329

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02317

|  |         |                              |  |  |      |   |        |                          |  |  |          |
|--|---------|------------------------------|--|--|------|---|--------|--------------------------|--|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                              | First Middle Last  |  |      | 2a. DATE KNOWN OF DEATH   |        |                          | 2b. HOUR   |  |          |
| GEORGE WASHINGTON RICE   |         |                              |  |  |      | Month Day Year  |        |                          | 5:30a  |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (in years last birthday)  | IF UNDER 1 YEAR  |      | IF UNDER 24 HRS   |        | 2c. DATE PRONOUNCED DEAD |  |  | 2d. HOUR |
| Male   | White   | Oct. 1, 1925                 | 42 YRS.  | MONTHS   | DAYS | HOURS   | MIN.   | Month Day Year           |  |  | 5:30a    |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      | 9. COUNTY OF DEATH  |        |                          | Md.  |  |          |
| Tenn.  |         | U. S. A.                     |  |  |      |   | Balto. |                          |  |  |          |
| 10. CITY OR TOWN OF DEATH  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |        |                          | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |
| Edgemere   |         |                              | 2500 ft. on Morse Rd.  |  |      |   |        |                          |  |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |                              | 13b. COUNTY  |  |      | 13c. CITY OR TOWN   |        |                          | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |          |
| Md.  |         |                              | Balto.   |  |      | Dundalk   |        |                          | 7413 St. Patricia Ct.  |  |          |
| 14. FATHER'S NAME  |         |                              | 15. MOTHER'S MAIDEN NAME   |  |      | First Middle Last   |        |                          | First Middle Last  |  |          |
| George Rice  |         |                              | Caroline   |  |      |   |        |                          |  |  |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |                              | 16b. SOCIAL SECURITY NO.   |  |      | 17. INFORMANT   |        |                          | ADDRESS  |  |          |
| Yes  |         |                              | 414 20 7338  |  |      | U. S. Army Records  |        |                          |  |  |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia due to Carbon Monoxide Poisoning</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                 |         |                              |  |  |      |   |        |                          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |
| 9520   |         |                              |  |  |      |   |        |                          |  |  |          |
| 9731   |         |                              |  |  |      |   |        |                          |  |  |          |
| 19a. DATE OF OPERATION   |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |      | 20. AUTOPSY?  |        |                          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |          |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>   |         |                              | 21b. TIME OF INJURY Month, Day, Year   |  |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |        |                          |  |  |          |
| CAUSE OF DEATH   |         |                              | ? P.M. ? 19  |  |      | Body found in Chev. truck over steering wheel   |        |                          |  |  |          |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |      | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |        |                          |  |  |          |
| XXXX Street (Truck)  |         |                              | 2500 ft. on Morse Rd. Edgemere Balto. Md.                                    |  |      |   |        |                          |  |  |          |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |      |   |        |                          |  |  |          |
| ACTUAL SIGNATURE   |         |                              | EDWARD F. WILSON M.D.  |  |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |        |                          | 22b. DATE SIGNED   |  |          |
| EXAMINER'S NAME (Type)   |         |                              | Edward F. Wilson, M.D.   |  |      | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |        |                          | February 7, 1968   |  |          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                              | 23b. DATE  |  |      | 23c. NAME OF CEMETERY OR CREMATORY  |        |                          | 23d. LOCATION (City or Town) (County) (State)  |  |          |
| Burial   |         |                              | Feb. 7, 1968   |  |      | Mt. Vista   |        |                          | Johnson City, Tenn.  |  |          |
| 24. FUNERAL DIRECTOR   |         |                              | 25. ADDRESS  |  |      | 26a. REC'D BY REGISTRAR   |        |                          | 25b. REGISTRAR'S SIGNATURE   |  |          |
| Howard county  |         |                              | Ellicott City Md.  |  |      | FEB 13 1968   |        |                          | Charles Judge  |  |          |
| Funeral Home Harry Witzke  |         |                              |  |  |      |   |        |                          |  |  |          |

11280

RECEIVED

03330

NOV 1954

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02330

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02318

|  |  |                                     |  |   |   |  |  |   |   |   |  |  |
|--|--|-------------------------------------|--|---|---|--|--|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |                                     | First Middle Last  |   |   | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> 2/26 1968 |  |   | 2b. HOUR<br>Noon  |   |  |  |
| NANCY  |  |                                     | MERRITT  |   |   | RIDDLE   |  |   |   |   |  |  |
| 3. SEX<br>female   |  | 4. RACE<br>white                    |  | 5. DATE OF BIRTH<br>4/7/1920  |   | 6. AGE (In years last birthday)<br>47 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>February 26, 1968 |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>Baltimore  |  |   | 2d. HOUR<br>4 P.M.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |                                     |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>50 Burkleigh Road   |   |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br>Homemaker |   |   | 12b. KIND OF BUSINESS OR INDUSTRY            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  |                                     |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>Towson  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>     |   | 13e. STREET AND NUMBER<br>50 Burkleigh Road                     |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Dr. Simon W. Merritt   |  |                                     |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Mary Haffelfinger  |   |  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) no   |  |                                     |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>213-18-0375  |   | 17. INFORMANT ADDRESS<br>Luther E. Riddle 50 Burkleigh Rd. #21204                    |  |   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage Due To Rupture<br>4309 XXXXXXXXXXXXXXXX Of Aneurysm of Circle of Willis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                                     |  |   |   |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>330X  |  |                                     |  |   |   |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  |                                     |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |  |                                     | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |  |   |   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                                     |  |   |   |  |  |   |   |   |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>Werner U. Spitz, M.D.  |  |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>ADDRESS (Street, city, town, or county) |   |   | 22b. DATE SIGNED<br>2/27/68  |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>burial  |  |                                     | 23b. DATE<br>2/29/68   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Grove |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Chambersburg, Pa.                                  |   |   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Mitchell-Wiedefeld Home 6500 York Rd.<br>Baltimore, Maryland 21212   |  |                                     |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 29 1968  |  |   | 25b. REGISTRAR'S SIGNATURE<br>J. Williams   |   |  |  |

05310

1086

4/1/1930

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD

STANDARD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02331  |  |  |  |  |  |  |  |  |  | 02319   |  |  |  |  |   |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| Items 2a & 5 Film G398 2/28/68 kk  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>JAMES F. RIDGELY</b>   |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH <b>2</b> Month <b>16</b> Day <b>68</b> Year |  |  |  |  | 2b. HOUR <b>M</b>                               |  |  |  |  |
| 3. SEX <b>m</b>  |  |  | 4. RACE <b>w</b>   |  |  | 5. DATE OF BIRTH <b>3/15/97</b>  |  |  | 6. AGE (In years last birthday) <b>70</b> YRS.   |   |  | IF UNDER 1 YEAR MONTHS DAYS                      |  |  | IF UNDER 24 HRS. HOURS MIN.                     |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>MD</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |   |  |  |  |  |   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>410 INGLETSIDE AVE</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>CLERK</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RET.</b>  |   |  |  |  |  |   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>  |  |  | 13b. COUNTY <b>BALTO</b>   |  |  | 13c. CITY OR TOWN <b>CATONSVILLE</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET AND NUMBER <b>410 INGLETSIDE AVE</b> |  |  |   |  |  |  |  |
| 14. FATHER'S NAME First Middle Last <b>George W. Ridgely</b>   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Ella Ebberts</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>NO</b> (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>215-07-5278</b>  |  |  |  |  | 17. INFORMANT <b>MRS. HELEN RIDGELY</b>                       |  |  |  |  | Address   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>CVA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ABCVD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>20 yrs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Wks</b>  |  |  |  |  |   |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |  |  |  |  |   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January 1967</b> , to <b>February 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb. 18</b> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <b>8 AM</b>              |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 22b. SIGNATURE <b>James E. Rowe M.D.</b>   |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED <b>2/19/68</b>                               |  |  |  |  |   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>James E. Rowe</b>  |  |  |  |  | 22e. ADDRESS <b>5550 Baltimore National Pike</b>   |  |  |  |  |   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  |  | 23b. DATE <b>2/21/68</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GOOD SHEPHERD</b>  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>HOWARD CO. MD.</b>                          |   |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>E.S. MACNABB</b>   |  |  |  |  | ADDRESS <b>301 FREDERICK RD 21228</b>  |  |  |  |  | 25a. REC'D BY REGISTRAR <b>FEB 21 1968</b>                    |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b> |  |  |  |  |

05831

01280

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |                                    |  |  |   |   |  |                                |
|---|--|---|--|---|------------------------------------|--|--|---|---|--|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |                                    |  |  |   |   |  |                                |
| CERTIFICATE OF DEATH  |  |   |  |   |                                    |  |  |   |   |  |                                |
| 02332   |  |   |  |   |                                    |  |  |   |   |  |                                |
| 02320   |  |   |  |   |                                    |  |  |   |   |  |                                |
| 1. DECEASED-NAME<br>(Type or print) <b>SAMUEL EARL RISTON</b>   |  |   | First Middle Last  |   |                                    | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>9<sup>th</sup></b> Year <b>1968</b>  |  |   | 2b. HOUR<br><b>2:15 AM</b>                          |  |                                |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>                         |  | 5. DATE OF BIRTH<br><b>2/27/1912</b>  |                                    |  | 6. AGE (In years last birthday)<br><b>55</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.           |  | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH<br><b>Baltimore County, Md.</b>   |  |   |   |  |                                |
| 10. CITY OR TOWN OF DEATH<br><b>Mount Wilson</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Wilson State Hospital</b> |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Laborer</b>                              |  |   | 12b. KIND OF BUSINESS OR INDUSTRY                   |  |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |  |   | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN <b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>113 S. Calhoun St.</b> |  |                                |
| 14. FATHER'S NAME<br>First <b>Samuel</b> Middle <b>Riston</b> Last <b>Riston</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Katherine</b> Middle <b>(?)</b> Last <b>(?)</b>                             |   |                                    | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW 2</b>         |  |   |   |  |                                |
| 16b. SOCIAL SECURITY NO.<br><b>220-05-7821</b>  |  |   | 17. INFORMANT<br><b>Mrs. Samuel E. Riston, Balto., Md. 21223</b><br><b>Records, Mt. Wilson State Hospital</b>    |   |                                    |  |  |   |   |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLI</b><br><b>451.0</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>463X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHEROSCLEROSIS LOWER EXTREMITIES</b> |  |   |  |   |                                    |  |  |   |   |  |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>FAR-ADVANCED PULMONARY TUBERCULOSIS</b>   |  |   |  |   |                                    |  |  |   |   |  |                                |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |                                    | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> |   |  |                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                     |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |   |  |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/24/1968</b> , to <b>2/9/1968</b> , that (I) (we) last saw the deceased alive on <b>2/9/1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |                                    |  |  |   |   |  |                                |
| 22b. SIGNATURE<br><b>W Newcomer</b>   |  |   |  |   |                                    | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED  |   |  |                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William Newcomer, M.D.</b>   |  |   |  |   |                                    | 22e. ADDRESS<br><b>Mount Wilson, Maryland</b>  |  |   |   |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-13-68</b>                     |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National C.</b>  |                                    |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                           |   |   |  |                                |
| 24. FUNERAL DIRECTOR<br><b>Witzke F. D., Balto., Md. 21229</b>  |  |   |  |   |                                    | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 13 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                              |   |  |                                |

05226

5050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |  |  |  |                        |  |  |  |
|--|--|--|--|--|--|--|--|------------------------|--|--|--|
| 02333  |  | MIDDLE   |  |  |  | 02321  |  |                        |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  | 2a. DATE OF DEATH  |  |                        |  | 2b. HOURa                                    |  |
| Russell Robert ROEHREN   |  |  |  |  |  | Month 2 Day 27 Year 68   |  |                        |  | 10:12  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR        |  | IF UNDER 24 HRS.                             |  |
| Male   |  | White  |  | 12/10/63   |  | 4 YRS.   |  | MONTHS DAYS            |  | HOURS MIN.                                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                        |  |  |  |
| Maryland   |  | U.S.A.   |  |  |  | Baltimore Md.  |  |                        |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                        |  |  |  |
| Owings Mills   |  | Rosewood State Hospital  |  | Dependent  |  | none   |  |                        |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |  |  |
| Maryland   |  | St. Mary's Co.   |  | Patuxent River   |  |  |  | MOQ 922-C NAS          |  |  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                        |  |  |  |
| First Middle Last  |  | First Middle Last  |  |  |  |  |  |                        |  |  |  |
| Robert Russell Roehren   |  | Lynn Gigi Lawrence   |  |  |  |  |  |                        |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address  |  |  |  |                        |  |  |  |
| no   |  | none   |  | Rosewood Records, Owings Mills, Maryland   |  |  |  |                        |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) External Hydrocephalus. DUE TO, OR AS A CONSEQUENCE OF (b) obstruction of Ventricle-Auricular Shunt 10 days. DUE TO, OR AS A CONSEQUENCE OF (c) 742X 752X                            |  |  |  |  |  |  |  |                        |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Subdural hemorrhage at birth with external Hydrocephalus   |  |  |  |  |  |  |  |                        |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes                     |  |                        |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                        |  |  |  |
| 21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |                        |  |  |  |
| 22a. I certify that (A) (this hospital) attended the deceased from 1/5, 1967, to 2/27, 1968, that (X) (we) last saw the deceased alive on 2/27, 1968, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above (B) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                        |  |  |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |  |  |  |  |                        |  |  |  |
| Richard A. Jones   |  | 2/28/68  |  |  |  |  |  |                        |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |  |  |  |  |                        |  |  |  |
| Richard A. Jones, M.D.   |  | Rosewood St. Hosp., Owings Mills, Md.  |  |  |  |  |  |                        |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)  |  |                        |  |  |  |
| Burial   |  | March 1, 68  |  | Arlington National   |  | Arlington Ma.  |  |                        |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                        |  |  |  |
| J. F. Eline & Sons   |  | Reisterstown, Md.  |  | DATE MAR 1 1968  |  | Charles Jones  |  |                        |  |  |  |

03333

CENTRAL BANK

03333

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |   |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First   |  | Middle  |  | Last   |  | 2a. DATE OF DEATH   |  | 2b. HOUR                                  |  |
| Joseph   |  |   |  |   |  | Rosenberg  |  | FEBRUARY 29 1968  |  | 6:19 M                                    |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |  |  |  | 6. AGE (In years<br>lost birthday)                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  |
| MALE   |  | WHITE   |  |   |  |  |  | 93 YRS.   |  |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |  |   |  |
| POLAND   |  | U.S.A.  |  |   |  | BALTIMORE Md.  |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |  |   |  |
| PIKESVILLE   |  | MILFORD MANOR NURSING HOME  |  |   |  | TATLOR - RETIRED   |  | CLOTHING  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 13e. STREET AND NUMBER  |  |   |  |
| VIRGINIA   |  |   |  | DANVILLE  |  |  |  | 312 RANDOLPH AVE.   |  |   |  |
| 14. FATHER'S NAME  |  | First   |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME  |  | First Middle Last                         |  |
|  |  | UNKNOWN   |  |   |  |  |  | UNKNOWN   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)   |  | (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | Address   |  |   |  |
| NO   |  |   |  | 231-60-4488   |  | DR. GERALD WAGGER  |  | 8815 STONEHAVEN RD<br>RANDALLSTOWN, MD 21138                            |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal failure (insufficiency)</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4500</u> |  |   |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |  | Street or R.F.D. No.   |  | City or Town  |  | County State                              |  |
|  |  |   |  |   |  |  |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-20-1963, to 2-29-1968, that (I) (we) last<br>saw the deceased alive on 2-28-1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED  |  |   |  | 22d. PHYSICIAN'S<br>NAME (Type)  |  |   |  |   |  |
| Gerald Wagger  |  | 2/29/68   |  |   |  | GERALD WAGGER  |  |   |  |   |  |
|  |  |   |  |   |  | 22e. ADDRESS   |  |   |  |   |  |
|  |  |   |  |   |  | 8815 STONEHAVEN RD., RANDALLSTOWN  |  |   |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)   |  | (County)  |  | (State)                                   |  |
| REMOVAL-BURIAL   |  | 2-29-68   |  | AETZ CHYM   |  | DANVILLE, VIRGINIA   |  |   |  |   |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS   |  |   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| SOL LEVINSON & BROS.   |  | 6010 REISTERSTOWN   |  |   |  | ROAD   |  | MAR 1 1968  |  |   |  |

02334

02334

02334

33

WHITE

WHITE

SALESMAN

U.S.A.

FOUR

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

UNKNOWN

UNKNOWN

NO

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

RECEIVED BY THE DIRECTOR OF THE BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |  |  |  |   |   |   |                                |   |  |
|--|--|---|--|---|--|--|--|---|---|---|--------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |  |  |   |   |   |                                |   |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |   |   |   |                                |   |  |
| 02335  |  |   |  |   |  |  |  |   |   |   |                                |   |  |
| 02323  |  |   |  |   |  |  |  |   |   |   |                                |   |  |
| 1. DECEASED-NAME<br>(Type or print) <b>KATHERINE D. ROSENTHAL</b>  |  |   | First Middle Last  |   |  | 2a. DATE OF DEATH<br><b>2</b> Month <b>8</b> Day <b>68</b> <sup>19</sup> <b>68</b>   |  |   | 2b. HOUR<br><b>M</b>  |   |                                |   |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>                           |  | 5. DATE OF BIRTH<br><b>2/11/85</b>  |  |  | 6. AGE (In years<br>lost birthday)<br><b>82</b> YRS. |   | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN. |   |  |
| 7a. BIRTHPLACE (State or foreign<br>country) <b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>BALTO.</b> Md.  |  |   |   |   |                                |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>302 RADSTOCK RD. HOUSEWIFE</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                    |   |                                |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE <b>Md</b>   |  |   | 13b. COUNTY <b>BALTO.</b>  |   |  | 13c. CITY OR TOWN<br><b>CATONSVILLE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>16 SHADY NOOK AVE.</b> |                                |   |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>GEORGE DIETRICH</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>KATHERINE EHRMAN</b>   |   |  |  |  |   |   |   |                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  |   | 16b. SOCIAL SECURITY NO.   |   |  | 17. INFORMANT<br>Address<br><b>HERMAN ROSENTHAL JR.</b>  |  |   |   |   |                                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4129 Cardiac arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Atherosclerotic myocardial</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Degeneration</b><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. |  |   |  |   |  |  |  |   |   |   |                                | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>4331</b>  |  |   |  |   |  |  |  |   |   |   |                                |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |                                |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |   |                                |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                      |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |   |   |                                |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Sund</b> , 19 <b>66</b> , to <b>8 Feb</b> , 19 <b>68</b> , that (I) (we) last<br>saw the deceased alive on <b>8 Feb</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |   |   |                                |   |  |
| 22b. SIGNATURE<br><b>William J. Bryant</b>   |  |   |  |   |  | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  |   | 22c. DATE SIGNED<br><b>9 Feb 68</b>                                     |   |                                |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |   |  |   |  | 22e. ADDRESS   |  |   |   |   |                                |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>2/10/68</b>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>      |   |                                |   |  |
| 24. FUNERAL DIRECTOR<br><b>E.S. MACNABB</b>  |  |   |  |   |  | ADDRESS<br><b>301 FREDERICK RD</b>   |  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 13 1968</b>                      |   |                                |   |  |
|  |  |   |  |   |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                        |   |                                |   |  |

FSEEC

EEESD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

| 02336  |  |  |  |  |  |  |  |  |  | 02324  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|------------------|--|--|--|--|-----------------------|--|--|--|--|------|--|--|--|--|---------|--|
| 1. DECEASED-NAME (Type or print) First Middle Last   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR                                      |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| INFANT   |  |  |  |  |  |  |  |  |  | MALC   |  |  |  |  |  |  |  |  |  | ROSSELLI                                      |  |  |  |  |                  |  |  |  |  | 2 Month 3 Day 68 Year |  |  |  |  |      |  |  |  |  | 9:15 PM |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years lost birthday)  |  |  |  |  | IF UNDER 1 YEAR                               |  |  |  |  | IF UNDER 24 HRS. |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| MALE   |  |  |  |  | WHITE  |  |  |  |  | 2-3-68   |  |  |  |  | YRS.   |  |  |  |  | MONTHS  |  |  |  |  | DAYS             |  |  |  |  | HOURS                 |  |  |  |  | MIN. |  |  |  |  |         |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |   |  |  |  |  | Md.              |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| MARYLAND   |  |  |  |  | U.S.   |  |  |  |  |  |  |  |  |  | TOWSON   |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| BALTIMORE  |  |  |  |  | G. B. M. C.  |  |  |  |  | NONE   |  |  |  |  | NONE   |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER                        |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| MD   |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  |  |  |  |  |  | 221E MONUMENT ST.                             |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| SALVATORE ROSSELLI   |  |  |  |  | JOANNA (NMN) SARDISCO  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT Address  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| NO   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>7735</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2-3-</u> , 19 <u>68</u> , to <u>2-3-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-3-</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 22b. SIGNATURE <u>John C Bolton MD</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED <u>2-3-68</u>   |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 22d. PHYSICIAN'S NAME (Type) <u>John C Bolton MD</u>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <u>Center Baltimore Medical Center Baltimore MD</u>                             |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE <u>Feb 1/68</u>  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u>                            |  |  |  |  |   |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |
| 24. FUNERAL DIRECTOR <u>Philip Newing Son</u> ADDRESS <u>2024 Calumet</u>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR <u>FEB 7 1968</u> DATE   |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>James Judge</u> |  |  |  |  |                  |  |  |  |  |                       |  |  |  |  |      |  |  |  |  |         |  |

#EES0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| 02337   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| 02325   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First<br><b>JOHN</b>   |  |  | Middle<br><b>ANTHONY</b>  |  |  | Last<br><b>RUSSO</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>22</b> Year <b>1968</b> |  |  | 2b. HOUR<br><b>12:30AM</b>        |  |  |
| 3. SEX<br><b>MALE</b>   |  |  | 4. RACE<br><b>WHITE</b>  |  |  | 5. DATE OF BIRTH<br><b>7/28/19</b>  |  |  | 6. AGE (In years<br>last birthday)<br><b>48</b> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   |  |  | IF UNDER 24 HRS.<br>HOURS<br>MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  | Md.   |  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>VETERANS ADMIN. HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>MECHANIC</b>   |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br><b>MARINE</b>   |  |  |   |  |  |                                   |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br><b>MARYLAND</b>   |  |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>2319 E. FAYETTE STREET</b>                   |  |  |                                   |  |  |
| 14. FATHER'S NAME<br>First<br><b>JOSEPH</b>   |  |  | Middle<br><b>- -</b>   |  |  | Last<br><b>RUSSO</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br><b>JOSEPHINE</b>   |  |  | Middle<br><b>- -</b>  |  |  | Last<br><b>GLORSIO</b>            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>YES</b>   |  |  | 16b. SOCIAL SECURITY NO. -<br>(If yes give war or dates of service)<br><b>WWII</b>                                 |  |  | 17. INFORMANT<br><b>217 07 54 26</b>  |  |  | Address<br><b>CLINICAL RECORDS, VAH. FT. HOWARD, MD.</b>  |  |  |   |  |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1621</b><br>IMMEDIATE CAUSE (a) <b>CANCER OF THE LUNG</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____             |  |  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>Months</b> |  |   |  |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>163x</b>   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?                         |  |  |   |  |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)   |  |  |   |  |  |   |  |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                                   |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>Feb. 12, 1968</b> , to <b>Feb. 22, 1968</b> , that <del>he</del> (we) last<br>saw the deceased alive on <b>Feb. 22, 1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the<br>causes stated above, <del>he</del> (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |   |  |  |                                   |  |  |
| 22b. SIGNATURE<br><b>Chong Choon Han</b>  |  |  | 22c. DATE SIGNED<br><b>2/22/68</b>   |  |  | 22d. PHYSICIAN'S<br>NAME (Type)<br><b>CHONG CHOON HAN, M.D.</b>   |  |  | 22e. ADDRESS<br><b>VAH, FT. HOWARD, MD.</b>   |  |  |   |  |  |                                   |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>Feb. 24, 1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY REDEEMER CEMETERY</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>                          |  |  |   |  |  |                                   |  |  |
| 24. FUNERAL DIRECTOR<br><b>BERNARD DABROWSKI, 2818 E. BALTIMORE, BALTO. MD.</b>   |  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 29 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |   |  |  |   |  |  |                                   |  |  |

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

05937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02338  |  |  |  |  |  |  |  |  |  | 02326  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR   |  |  |  |  |
| ANNA   |  |  |  |  | E RYDER  |  |  |  |  | FEB. 16. 68.   |  |  |  |  | M  |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |
| FEMALE.  |  |  |  |  | WHITE  |  |  |  |  | JULY 2-1890.   |  |  |  |  | 77 YRS.  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |
| VIRGINIA   |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  | BALTIMORE Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |
| COCKEYSVILLE   |  |  |  |  | MARYLAND MASONIC HOMES   |  |  |  |  | HOUSEWIFE  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |
| MD.  |  |  |  |  | BALTIMORE  |  |  |  |  | BALTIMORE  |  |  |  |  | 5 BRIARWOOD RD.  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HENRY  |  |  |  |  | HARRINGTON   |  |  |  |  | FLORENCE LOWERY.   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  | Address  |  |  |  |  |
| No   |  |  |  |  | 215-05-9263  |  |  |  |  | Smyllings Rn. Maryland Masonic Homes.  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF 3 arterial fibrillation   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF 3 Pulmonary embolism   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4200   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION  |  |  |  |  | Street or R.F.D. No. City or Town County State   |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 19 65, to Feb 16, 19 68, that (I) (we) lost the deceased alive on Feb 16, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 4:55 PM. 2/16/68 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE   |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                                     |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |
| JAMES HED HAMED MD   |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 2/16/68  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| JAMES HED HAMED MD   |  |  |  |  | MASONIC HOME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |
| BURIAL   |  |  |  |  | 2/19/68  |  |  |  |  | LORRAINE PARK CEMETERY   |  |  |  |  | WOODLAWN, MD.  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |
| Wm. COOK-BROOKS TOWSON, 1050 YORK RD 21204   |  |  |  |  |  |  |  |  |  | DATE FEB 21 1968   |  |  |  |  | Charles J. J...  |  |  |  |  |

## REFERENCES

COCKEYVILLE

WASH

WASHINGTON PLANTS THREE

*[Faint handwritten notes at the bottom of the page]*

Walter D. Williams

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-43. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                  |   |  |   |  |   |  |   |  |   |  |
|---|------------------|---|--|---|--|---|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                  |   |  |   |  |   |  |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or Print) <b>MARGARET</b>   |                  | First   |  | Middle <b>SANDEBECK</b>   |  | Last <b>SANDEBECK</b>   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Feb</b> Day <b>19</b> Year <b>1968</b> |  | 2b. HOUR <b>10:55 PM</b>  |  |
| 3. SEX <b>F</b>   | 4. RACE <b>W</b> | 5. DATE OF BIRTH <b>2-10-93</b>   |  | 6. AGE (In years last birthday) <b>75</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN <b>0</b>  |  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Feb</b> Day <b>19</b> Year <b>1968</b> |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |                  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.   |  |   |  |   |  |
| 1d. CITY OR TOWN OF DEATH <b>Towson</b>   |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph's Hosp</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NONE</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>   |                  | 13b. COUNTY <b>BALTO.</b>   |  | 13c. CITY OR TOWN <b>Towson</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>        |  | 13e. STREET AND NUMBER <b>313 GARDEN RD.</b>  |  |   |  |
| 14. FATHER'S NAME First <b>Milton</b> Middle <b>H.</b> Last <b>Crandall</b>   |                  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>J.</b> Last <b>Carter</b>  |  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>                                |  |   |  |
| 16b. SOCIAL SECURITY NO. <b>215-09-0967D</b>  |                  |   |  | 17. INFORMANT: <b>Dghtr-in-law</b> ADDRESS <b>Towson, Md. 21204</b><br><b>Mrs. David M. Sandebeck, 313 Garden Rd.</b>                                       |  |   |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SUBDURAL HEMATOMA</b><br>880X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____  |                  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 DAY</b>                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>9000</b>   |                  |   |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |                  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 2d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>2</b> P.M. <b>18</b> 19 <b>68</b>                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>FELL DOWN STEPS</b>   |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Home</b>           |  | 21f. LOCATION Street or R.F.D. No. <b>313 GARDEN RD</b>   |  | City or Town <b>TOWSON</b>  |  | County <b>BALTO</b>   |  | State <b>MD</b>   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                  |   |  |   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b>  |                  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | 22b. DATE SIGNED <b>2/20/68</b>   |  |   |  |
| EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>  |                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
|   |                  |   |  | ADDRESS (Street, city, town, or county) <b>BALTO CO.</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                  | 23b. DATE <b>Feb. 23, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>   |  | 23d. LOCATION (City or Town) <b>Parkville, Balto. Co., Md.</b>                                      |  | (County)  |  | (State)   |  |
| 24. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO. 108 W. North Av., Balto. 1</b>  |                  | ADDRESS   |  | 25a. REC'D BY REGISTRAR <b>FEB 21 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |   |  |   |  |



02339

02339

1950

Mar. 1950

Town

Town

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950

Mar. 1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02340</div> <div> <div>2</div> <div>1</div> </div> <div> <div>02328</div> <div>10:15 A.M.</div> </div>  |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
|--|--|--|--|--|--|---|--|-----------|---|------|--|--|--|----------------------------|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  | First   |  | Middle    |   | Last |  | 2a. DATE OF DEATH                            |  | 2b. HOUR                   |  |
| Paul   |  |  |  |  |  |   |  | SAUERBREY |   |      |  | February 21, 1968                            |  | 10:15 A.M.                 |  |
| 3. SEX   |  |  | 4. RACE  |  |  | 5. DATE OF BIRTH  |  |           | 6. AGE (In years last birthday)   |      |  | IF UNDER 1 YEAR                              |  | IF UNDER 24 HRS.           |  |
| Male   |  |  | White  |  |  | September 17, 1883  |  |           | 84 RS   |      |  | MONTHS DAYS                                  |  | HOURS MIN.                 |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  |           | 9. COUNTY OF DEATH  |      |  |  |  |                            |  |
| Germany  |  |  | U.S.A.   |  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      |  |           | Baltimore,  |      |  | Md.  |  |                            |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |           | 12b. KIND OF BUSINESS OR INDUSTRY   |      |  |  |  |                            |  |
| Towson   |  |  | ST. JOSEPH HOSPITAL  |  |  | Machinest   |  |           | Thau Co.  |      |  |  |  |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |           | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |      |  | 13e. STREET AND NUMBER                       |  |                            |  |
| Maryland   |  |  | Balto.   |  |  | Baltimore   |  |           |   |      |  | 4528 Ridge Rd.                               |  |                            |  |
| 14. FATHER'S NAME  |  |  | First  |  |  | Middle  |  |           | Last  |      |  | 15. MOTHER'S MAIDEN NAME                     |  |                            |  |
| Unknown  |  |  |  |  |  |   |  |           |   |      |  | Unknown                                      |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |           | Address   |      |  |  |  |                            |  |
| No   |  |  | 214-20-0218B   |  |  | Mrs Johanna J. Sauerbrey  |  |           | A528 Ridge Road   |      |  | 36   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |           |   |      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                            |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
| IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease  |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201  |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
| (c)  |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
| Superimposed uremia  |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |           | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |      |  |  |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19                              |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |           |   |      |  |  |  |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |           |   |      |  |  |  |                            |  |
| 22a. I certify that (this hospital) attended the deceased from 2/20/1968, to 2/21/1968, that (I) (we) last saw the deceased alive on 2/21/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |           |   |      |  |  |  |                            |  |
| 22b. SIGNATURE   |  |  |  |  |  |   |  |           |   |      |  | 22c. DATE SIGNED                             |  |                            |  |
| Ramon P. Lopez, M.D. DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |           |   |      |  | February 21, 1968                            |  |                            |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  | 22e. ADDRESS  |  |           |   |      |  |  |  |                            |  |
| Ramon P. Lopez, M.D.   |  |  |  |  |  | 7620 York Rd., Towson, Md. 21204  |  |           |   |      |  |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |           | 23d. LOCATION (City or Town) (County) (State)                                     |      |  |  |  |                            |  |
| Burial   |  |  | 2-24-1968  |  |  | Moreland Memorial Cemetery  |  |           | Baltimore Cp. Md.   |      |  |  |  |                            |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  | ADDRESS   |  |           |   |      |  | 25a. REC'D BY REGISTRAR                      |  | 25b. REGISTRAR'S SIGNATURE |  |
| Lassahn Funeral Home   |  |  |  |  |  | 7401 Belair Road  |  |           |   |      |  | FEB 23 1968                                  |  | Charles Judge              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |                        |  |
|---|--|--|--|---|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |                        |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |                        |  |
| 02341   |  |  |  |   |  |   |  |  |                        |  |
| 02329   |  |  |  |   |  |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH   |  | 2b. HOUR                                     |                        |  |
| Caroline L Saunders   |  |  |  |   |  | Feb 4 1968  |  | M  |                        |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.    |                        |  |
| Female  |  | White  |  | 8-1-1877  |  | 90 YRS.   |  |  |                        |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | Md.  |                        |  |
| Balto. Co. - Md.  |  | U.S.A.   |  |   |  | Baltimore   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY            |                        |  |
| Catonsville   |  |  | Summit Nurs. Hme   |   |  | Housewife   |  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Md.   |  |  | Howard   |   | RFD 2 - E.C.   |   |  |  |                        |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |  |  |                        |  |
| First Middle Last   |  |  | First Middle Last  |   |  |   |  |  |                        |  |
| George Wolfe  |  |  | Mary Hoffman   |   |  |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   | Address  |  |                        |  |
| no  |  |  |  |   | G. Nobel Saunders  |   | RFD 2 Ellicott City, Md.   |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4274 Chronic Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF Atrial Fibrillation<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4331  |  |  |  |   |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |                        |  |
|   |  |  |  |   |  |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |                        |  |
| 22b. SIGNATURE  |  |  |  |   |  | 22c. DATE SIGNED  |  |  |                        |  |
| Emilio J. Blau  |  |  |  |   |  |   |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |   |  | 22e. ADDRESS  |  |  |                        |  |
|   |  |  |  |   |  | 3350 Wilkins Ave BALTO.   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                        |  |
| Burial  |  | Feb. 7, 1968   |  | National Cemetery - Balto.  |  | Baltimore Md.   |  |  |                        |  |
| 24. FUNERAL DIRECTOR  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                   |                        |  |
| Niginbitham-Slack   |  |  |  | 106 Columbia Rd. Ellicott City, Md.   |  | DATE FEB 8 1968   |  | f Charles Judge                              |                        |  |

03301

03301

03301

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "Cable" and "Date" are visible.]*

*[Faint vertical text along the right margin, possibly bleed-through from the reverse side.]*

CERTIFICATE OF DEATH

023310

|   |                         |  |   |  |  |   |  |
|---|-------------------------|--|---|--|--|---|--|
| 1. DECEASED-NAME (Type or print) <i>Sk. M. Pamphalia Schmitt</i>  |                         |  | 2a. DATE OF DEATH<br>Month <i>2</i> Day <i>8</i> Year <i>1968</i> |  |  | 2b. HOUR <i>10 P M</i>  |  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i> | 5. DATE OF BIRTH<br><i>9-18-1873</i>   |   | 6. AGE (In years last birthday)<br><i>94</i> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Penn.</i>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. COUNTY OF DEATH<br><i>Baltimore</i> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Glen Arm</i>  |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Glen Arm, Road</i>                                  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Teacher</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |                         | 13b. COUNTY<br><i>Baltimore</i>  |   | 13c. CITY OR TOWN<br><i>Glen Arm, Rd.</i>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 14. FATHER'S NAME (First Middle Last)<br><i>Philip Schmitt</i>  |                         | 15. MOTHER'S MAIDEN NAME (First Middle Last)<br><i>Catherine Tittelbach</i>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><i>218-54-0805</i>  |  |
| 17. INFORMANT<br><i>Sk. M. Kathleen</i>   |                         | 18. ADDRESS<br><i>same</i>   |   | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>4270</i><br>IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Fracture Left Hip</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Natural causes</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>4341</i>             |                         |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) |                         | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><i>6 P.M. Nov 19 1968</i>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)<br><i>Slipped on floor</i>   |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work                    |                         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)<br><i>Villa Maria Rest Home</i>                           |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><i>Glen Arm Balto. Md.</i>   |  | 22a. I certify that (I) (this hospital) attended the deceased from <i>11-3-</i> , 19 <i>66</i> , to <i>2-8</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2-8-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |
| 22b. SIGNATURE<br><i>Henry L McCorkle</i>   |                         | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)<br><i>HENRY L MCCORKLE</i>   |  |
| 22e. ADDRESS<br><i>Phoenix Maryland 21131</i>   |                         | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |   | 23b. DATE<br><i>2-12-68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>SISTERS CEMETERY</i>   |  |
| 23d. LOCATION (City or town) (County) (State)<br><i>Glen Arm Balt MARYLAND</i>  |                         | 24. FUNERAL DIRECTOR<br><i>RAYMOND CURRAN</i>  |   | 25a. REC'D BY REGISTRAR<br>DATE <i>FEB 19 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05230

05230

05230

05230



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
30M REV. 1/68

| 02343   |  |                              |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |        |                                    |                          | 02331   |    |  |          |  |        |
|---|--|------------------------------|--|--|--------|------------------------------------|--------------------------|---|----|--|----------|--|--------|
| 1. DECEASED-NAME<br>(Type or print)   |  |                              |  | First  | Middle | Last                               | 2a. DATE OF DEATH        |   |    |  | 2b. HOUR |  |        |
| Edmund Carroll Schofield  |  |                              |  |  |        |                                    | 2                        | Month   | 24 | Day  | 68       | Year   | 7:50AM |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |        |                                    |                          | 6. AGE (In years last birthday)   |    | IF UNDER 1 YEAR  |          | IF UNDER 24 HRS                              |        |
| M   |  | W                            |  | 8/25/1888  |        |                                    |                          | 79  |    | MONTHS   |          | DAYS   |        |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED   |        | NEVER MARRIED                      |                          | 9. COUNTY OF DEATH  |    |  |          |  |        |
| Md.   |  | USA                          |  | WIDOWED  |        | DIVORCED                           |                          | Baltimore   |    | Md.  |          |  |        |
| 10. CITY OR TOWN OF DEATH   |  |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        |                                    |                          | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |    |  |          | 12b. KIND OF BUSINESS OR INDUSTRY            |        |
| Towson  |  |                              |  | Stella Maris Hospice   |        |                                    |                          | Grounds keeper OrioleP  |    |  |          | Ball Park                                    |        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              |  | 13b. COUNTY  |        |                                    |                          | 13c. CITY OR TOWN   |    | 13d. INSIDE CITY LIMITS?   |          | 13e. STREET AND NUMBER                       |        |
| Md  |  |                              |  | Baltimore  |        |                                    |                          | YES   |    | NO   |          | 2900 Greenmount Ave                          |        |
| 14. FATHER'S NAME   |  |                              |  | First  | Middle | Last                               | 15. MOTHER'S MAIDEN NAME |   |    |  | First    | Middle                                       | Last   |
| Henry Carroll Schofield   |  |                              |  |  |        |                                    | Rebecca Jane Evans       |   |    |  |          |  |        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |                              |  | 16b. SOCIAL SECURITY NO.   |        |                                    |                          | 17. INFORMANT   |    |  |          | Miss Mary Shehan 100-4, Cold Spring Lane     |        |
| yes   |  |                              |  | W.W.I  |        |                                    |                          | 215-00-9397   |    |  |          | Hospice records                              |        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |        |                                    |                          |   |    |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |        |
| PART 1. DEATH WAS CAUSED BY:  |  |                              |  |  |        |                                    |                          |   |    |  |          |  |        |
| IMMEDIATE CAUSE (a)   |  |                              |  |  |        |                                    |                          |   |    |  |          | Uremia                                       |        |
| 4129  |  |                              |  |  |        |                                    |                          |   |    |  |          | DUE TO, OR AS A CONSEQUENCE OF               |        |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |                              |  |  |        |                                    |                          |   |    |  |          | (b) ASCVD.                                   |        |
|   |  |                              |  |  |        |                                    |                          |   |    |  |          | (c) Bmgs Chronic Hepatitis                   |        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                              |  |  |        |                                    |                          |   |    |  |          |  |        |
| 4221  |  |                              |  |  |        |                                    |                          |   |    |  |          |  |        |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        |                                    |                          | 20a. AUTOPSY?   |    | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |          |  |        |
|   |  |                              |  |  |        |                                    |                          | YES   |    | NO   |          |  |        |
| 21a. ACCIDENT WAS UNDERLYING  |  |                              |  | 21b. TIME OF INJURY  |        |                                    |                          | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |    |  |          |  |        |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              |  | HOUR A.M. Month Day Year   |        |                                    |                          |   |    |  |          |  |        |
|   |  |                              |  | P.M. 19  |        |                                    |                          |   |    |  |          |  |        |
| 21d. INJURY OCCURRED  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        |                                    |                          | 21f. LOCATION   |    |  |          |  |        |
| While <input type="checkbox"/> Not while <input type="checkbox"/>   |  |                              |  |  |        |                                    |                          | Street or R.F.D. No. City or Town County State  |    |  |          |  |        |
| at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              |  |  |        |                                    |                          |   |    |  |          |  |        |
| 22a. I certify that (I) (this hospital) attended the deceased from 10/11/67, 19__, to 2/24/68, 19__, that (I) (we) last saw the deceased alive on 2/23/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |        |                                    |                          |   |    |  |          |  |        |
| 22b. SIGNATURE  |  |                              |  | 22c. DATE SIGNED   |        |                                    |                          |   |    |  |          |  |        |
| Robert J. Mahon   |  |                              |  | 2/24/68  |        |                                    |                          |   |    |  |          |  |        |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              |  | 22e. ADDRESS   |        |                                    |                          |   |    |  |          |  |        |
| Robert J. Mahon, M.D.   |  |                              |  | 204 E. Joppa Rd  |        |                                    |                          |   |    |  |          |  |        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY |                          |   |    | 23d. LOCATION (City or Town) (County) (State)                        |          |  |        |
| Burial  |  |                              |  | 2/27/68  |        | New Cathedral                      |                          |   |    | Baltimore, Maryland  |          |  |        |
| 24. FUNERAL DIRECTOR  |  |                              |  | ADDRESS  |        |                                    |                          | 25a. REC'D BY REGISTRAR   |    | 25b. REGISTRAR'S SIGNATURE   |          |  |        |
| Mitchell-Wiedefeld Home   |  |                              |  | 6500 York Rd.  |        |                                    |                          | DATE  |    | FEB 29 1968  |          |  |        |
|   |  |                              |  | Baltimore, Maryland 21212  |        |                                    |                          |   |    |  |          |  |        |

15330

RECEIVED

15330

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |                        |  |
|--|--|--|--|---|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |                        |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |                        |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |  | 20. DATE OF DEATH   |  | 2b. HOUR   |                        |  |
| Mary Anne  |  |  | Elizabeth Schwartz   |   |  | Month Day Year<br>2 18 1968   |  | 1.15A  |                        |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.              |                        |  |
| Female   |  | White  |  | 6-16-1880   |  | 87 YRS.   |  |  |                        |  |
| 70. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  | Md.  |                        |  |
| Baltimore MD.  |  | U.S.A.   |  |   |  | Baltimore   |  |  |                        |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY                      |                        |  |
| Lutherville  |  |  | College Manor Nursing Home   |   |  | House Wife  |  |  |                        |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER |  |
| Md.  |  |  | Baltimore  |   | Baltimore  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  | 212 Rodgers Forge      |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |  |   |  |  |                        |  |
| First Middle Last  |  |  | First Middle Last  |   |  |   |  |  |                        |  |
| John White   |  |  | Jennie McGibbon  |   |  |   |  |  |                        |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |   | Address  |  |                        |  |
| No   |  |  | 216-05-9509-D  |   | Mrs. Elizabeth S. Totman   |   | 15 Meadow Rd.  |  |                        |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial infarction</u><br>4109<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Arteriosclerotic cardiovascular disease</u><br>11+ yrs<br>(c) <u>Diabetes mellitus</u><br>4201 |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 min |                        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |   |  |   |  |  |                        |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                        |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |                        |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |                        |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Feb 16</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Jan 9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.            |  |  |  |   |  |   |  |  |                        |  |
| 22b. SIGNATURE<br><u>Frederick J. Vollmer MD</u>   |  |  |  |   | 22c. DATE SIGNED<br><u>Feb 16, 1968</u>                                |   |  |  |                        |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. Frederick J. Vollmer   |  |  |  |   | 22e. ADDRESS<br>6100 York Road, Balto, Md.                             |   |  |  |                        |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |                        |  |
| Burial   |  | 2/19/68  |  | Parkwood Cemetery   |  | Baltimore Co., Md.  |  |  |                        |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc.-Balto, Md.-14  |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE<br>FEB 16 1968                         |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |                        |  |

02334

02333

1.1.1 0001 I 3 000000 000000

1-1-1

001

1-1-1

000000

000000

000000

000000 000000 000000 000000

000000

000000 000000 000000 000000

000000

000000

000000

000000

000000

000000 000000 000000

000000 000000 000000

000000

000000 000000 000000

000000

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02345

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02333

|  |         |                  |  |                                |                               |  |  |  |  |  |  |
|--|---------|------------------|--|--------------------------------|-------------------------------|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                  | First Middle Last  |                                |                               | 2a. DATE KNOWN OF ESTI-DEATH MATED   |  |  | 2b. HOUR   |  |  |
| MARION EDWARD SCOTT  |         |                  |  |                                |                               | Month Day Year   |  |  | 21 1968 7:37   |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS | IF UNDER 24 HRS.<br>HOURS MIN | 2c. DATE PRONOUNCED DEAD   |  |  | 2d. HOUR   |  |  |
| Male   | Colored | 6-17-1945        | 22 YRS.  |                                |                               | Month Day Year   |  |  | 21 1968 7:37M  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |                                |                               | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |  |
| Sparks., Md.   |         |                  | U.S.A.   |                                |                               |  |  |  | Balto. Md.   |  |  |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                                |                               | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Balto.   |         |                  | St. Joseph Hospital  |                                |                               | None   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE  |         |                  | 13b. COUNTY  |                                |                               | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| Md.  |         |                  |  |                                |                               | Balto.   |  |  | 5106 Craig Avenue  |  |  |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME   |                                |                               | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  |
| UNK.   |         |                  | MARION SCOTT OAKLEY  |                                |                               | NO   |  |  |  |  |  |
| 17. INFORMANT  |         |                  | ADDRESS  |                                |                               | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia                       |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| Mrs. Marion S. Oakley  |         |                  | 5106 Craig Ave   |                                |                               | 916 X DUE TO, OR AS A CONSEQUENCE OF Compression of trachea  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |                                |                               | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH   |         |                  | 21b. TIME OF INJURY Month, Day, Year   |                                |                               | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |
|  |         |                  | ? P.M. 2 21 19 68  |                                |                               | Jack slipped and car fell on subject   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> OR NOT WHILE AT WORK <input type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                                |                               | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |
|  |         |                  | XXX St.  |                                |                               | Western Run Rd. Cockeysville Balto. Md.  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  | 22b. DATE SIGNED   |                                |                               | 22c. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| ACTUAL SIGNATURE   |         |                  | EXAMINER'S NAME (Type)   |                                |                               | 23a. REC'D BY REGISTRAR  |  |  | 23b. REGISTRAR'S SIGNATURE   |  |  |
| Edward F. Wilson, M.D.   |         |                  |  |                                |                               | DA FEB 23 1968   |  |  | Charles Judge  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         |                  | 23b. DATE  |                                |                               | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Burial   |         |                  | 2-25-68  |                                |                               | Union Chapel Cem.  |  |  | Northern Balto. Co., Md.   |  |  |
| 24. FUNERAL DIRECTOR   |         |                  | ADDRESS  |                                |                               | 25a. REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| MORTON & DYETT F.H.  |         |                  | 1701 Laurens St.   |                                |                               | DA FEB 23 1968   |  |  | Charles Judge  |  |  |

02343

02343

MINERAL SPRINGS, MISSISSIPPI

4-17-1945

U.S.A.

one

X 5105 State Avenue

Salto

Poston Scott

Poston Scott

Poston Scott

Poston Scott

Poston Scott

Poston Scott

Poston Scott

Poston Scott

Union Church Co., Me.

Union Church Co., Me.

Poston

Poston



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02346  |  |  |  | MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  | 02334                   |  |                   |  |
|--|--|--|--|---|--|--|--|-------------------------|--|-------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |                         |  |                   |  |
| Item 5 Film G398 2/28/68 kk  |  |  |  |   |  |  |  |                         |  |                   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First Middle Last  |  | 2a. DATE OF DEATH   |  | Month Day Year   |  | 2b. HOUR                |  |                   |  |
| Aline  |  | Cales  |  | Seccomb   |  | Feb. 23, 1968  |  | 3:15 P.M.               |  |                   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR         |  | IF UNDER 24 HRS.  |  |
| Female   |  | White  |  | Mar. 4, 1892/1891   |  | 76 YRS.  |  | MONTHS DAYS HOURS MIN.  |  |                   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                         |  |                   |  |
| Penna.   |  | U. S. A.   |  |   |  | Baltimore, County  |  |                         |  | Md.               |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |                         |  |                   |  |
| Catonsville,   |  | House in the Pines N. H.   |  | Housewife   |  | Own Home   |  |                         |  |                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER  |  | 13f. ADDRESS      |  |
| Maryland   |  | Camp Springs, Md.  |  |   |  |  |  | 7345 Chesterfield Drive |  | Wash. D. C. 20031 |  |
| 14. FATHER'S NAME  |  | First Middle Last  |  | 15. MOTHER'S MAIDEN NAME  |  | First Middle Last  |  |                         |  |                   |  |
| Sheridan Coles   |  |  |  | Nora Stacey   |  |  |  |                         |  |                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address  |  |                         |  |                   |  |
| No   |  |  |  | Col. M. L. Seccomb  |  | Washington D. C. 20031   |  |                         |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |                         |  |                   |  |
| 4129 Myocardial Decompensation   |  |  |  | 1 wk.   |  |  |  |                         |  |                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221  |  | (b) Arteriosclerotic Cardio-Vascular Disease                                 |  | 10 yr.  |  |  |  |                         |  |                   |  |
|  |  | (c)  |  |   |  |  |  |                         |  |                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |  |  |                         |  |                   |  |
| Chronic Brain Syndrome   |  |  |  |   |  |  |  |                         |  |                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |                         |  |                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |                         |  |                   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |                         |  |                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-19-1965, to 2-23-1968, that (I) (we) last saw the deceased alive on 2-23-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |                         |  |                   |  |
| 22b. SIGNATURE   |  | 22c. DATE SIGNED   |  |   |  |  |  |                         |  |                   |  |
| Wilmer K. Gallagher M.D.   |  | 2-23-68  |  |   |  |  |  |                         |  |                   |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |   |  |  |  |                         |  |                   |  |
| Wilmer K. Gallagher, M.D.  |  | 6209 Frederick Ave, Balt, Md. 21228  |  |   |  |  |  |                         |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. NAME OF CEMETERY OR CREMATORY   |  | 23c. LOCATION (City or Town) (County) (State)   |  |  |  |                         |  |                   |  |
| Transportation - 2/24/1968   |  | Prospect Cemetery  |  | Mansfield Tioga Co. Penna.  |  |  |  |                         |  |                   |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REG. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |                         |  |                   |  |
| Easton Funeral Home  |  | Catonsville, Md.   |  | FEB 26 1968   |  | J. J. Jones  |  |                         |  |                   |  |

0250

2000

6-5555

251

100

100

05. 05

2

• • •

250

•

0.250

2. 7. 1900.

1.

7202-109

2015-2016-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|  |  |  |  |   |  |   |  |   |   |   |                      |  |
|--|--|--|--|---|--|---|--|---|---|---|----------------------|--|
| 02347  |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 02335   |  |   |   |   |                      |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH<br>Month Day Year                                     |   |   | 2b. HOUR<br>11:00 AM |  |
| GEORGIA PRESTMAN SELMAIER  |  |  |  |   |  |   |  | 2   |   |   | 11                   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>August 16, 1880   |  |   |  | 6. AGE (In years<br>last birthday)<br>87 YRS.                           |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |                      |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>MISSOURI   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE Md.   |  |   |   |   |                      |  |
| 10. CITY OR TOWN OF DEATH<br>RANDALLSTOWN  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>3843 BROWN HILL ROAD            |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>HOUSEWIFE |  |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>HOUSEWORK |   |                      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>RANDALLSTOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 13e. STREET AND NUMBER<br>3843 BROWN HILL RD.                           |   |   |                      |  |
| 14. FATHER'S NAME<br>(unknown)   |  | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME<br>(unknown)                                   |   | First                                     |                      |  |
|  |  |  |  |   |  |   |  |   |   |   |                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or unknown  |  | 16b. SOCIAL SECURITY NO.<br>216-56-5902  |  | 17. INFORMANT<br>Mrs. Elizabeth Truitt  |  |   |  | Address<br>3843 BROWN HILL RD.<br>RANDALLSTOWN, MD.                     |   |   |                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) UREMIA<br>4409<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) GENERALIZED ARTERIO SCLEROSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>4500<br>APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 MONTHS<br>5 YEARS |  |  |  |   |  |   |  |   |   |   |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |   |   |   |                      |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |   |   |                      |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |   |   |                      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |   |   |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT. 10, 1954, to FEB. 11, 1968, that (I) (we) last<br>saw the deceased alive on FEB. 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |   |  |   |  |   |   |   |                      |  |
| 22b. SIGNATURE<br>Edwin L. Pierpont, M.D.  |  | DEGREE   |  | ATTENDING<br>PHYS.  |  | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS.               |  | 22c. DATE SIGNED<br>2/11/68   |   |   |                      |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>EDWIN L. PIERPONT, M.D.   |  | 22e. ADDRESS<br>8204 LIBERTY RD. BALTO. 21207 MD.  |  |   |  |   |  |   |   |   |                      |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>2/14/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olive Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Randallstown Balt. MD                                  |  |   |   |   |                      |  |
| 24. FUNERAL DIRECTOR<br>Loring Byers 8728 Liberty Road   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 13 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |   |   |   |                      |  |

03380

UNITED STATES OF AMERICA

03380

(continued)

(continued)

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02348  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02336  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)  |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| BLANCHE  |  |  |  |  | KATHERINE  |  |  |  |  | SEWELL   |  |  |  |  | Month 2 Day 4 Year 68  |  |  |  |  | 11: AM   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  | IF UNDER 1 YEAR  |  |  |  |  | IF UNDER 24 HRS.                             |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| FEMALE   |  |  |  |  | CAU  |  |  |  |  | 7-5-1901   |  |  |  |  | 66 YRS.  |  |  |  |  | MONTHS   |  |  |  |  | DAYS   |  |  |  |  | HOURS   |  |  |  |  | MIN                        |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  | Md.  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| MARYLAND   |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| BALTIMORE  |  |  |  |  | GREATER BALT. MED. CENT  |  |  |  |  |  |  |  |  |  | Housewife  |  |  |  |  |  |  |  |  |  | own home                                     |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| MARYLAND   |  |  |  |  | BALTIMORE  |  |  |  |  | BALTIMORE  |  |  |  |  |  |  |  |  |  | 117 SHERWOOD AVE   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  | First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| BENJAMIN   |  |  |  |  | LEONARD FORWARD  |  |  |  |  | BERTHA   |  |  |  |  | VIOLA  |  |  |  |  | JUSTICE  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| UNKN   |  |  |  |  | 214-20-6489  |  |  |  |  | CHART  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Massive G.I. Bleeding  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 2509 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| (b) ASCVD - Congestive Heart failure   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| (c) Diabetes melitus   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 260X   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/3, 1968, to 2/4, 1968, that (I) (we) last saw the deceased alive on 11:50 AM 2/4 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Parviz Navidi   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DEGREE                                       |  |  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED 2/4/68    |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | Parviz Navidi  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  | Feb. 7, 1968   |  |  |  |  | Grace Valley Rd. Beltsville  |  |  |  |  | Beltsville Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | ADDRESS                                      |  |  |  |  | 25a. RECD BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE |  |  |  |  |  |  |  |  |  |
| Frank H. Sewell, Beltsville, Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 1-5-68  |  |  |  |  | Charles Judge              |  |  |  |  |  |  |  |  |  |

03336

COPIES OF DEATH

03336

DEATH CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

03336

DEATH CERTIFICATE



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02349

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02337

|   |                        |  |  |   |   |   |   |   |
|---|------------------------|--|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(Type or Print) <b>MILDRED EVELYN SHAMBERGER</b>  |                        |  | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>Feb 19 1968</b> |   |   | 2b. HOUR <b>4P M</b>  |   |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Cau.</b> | 5. DATE OF BIRTH<br><b>Feb. 3, 1903</b>                                      | 6. AGE (In years last birthday)<br><b>65</b> YRS   | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>               | IF UNDER 24 HRS<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD<br>Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>Feb 19 1968</b> |   |   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b>  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Parkton</b>   |                        |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Mt. Carmel Road</b>   |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Secretary</b>     |   | 12b. KIND OF BUSINESS OR INDUSTRY                     |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |                        |  | 13b. COUNTY <b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Parkton</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 | 13e. STREET AND NUMBER<br><b>Mt. Carmel Rd.</b> |   |
| 14. FATHER'S NAME First Middle Last<br><b>Charles Keys</b>  |                        |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Clara Britton</b>   |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |                        |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service) <b>214-22-8952A</b>  |   | 17. INFORMANT ADDRESS<br><b>Thomas E. Shamberger, Same as # 13</b>              |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4129 Coronary Occlusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |                        |  |  |   |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |                        |  |  |   |   |   |   |   |
| 19a. DATE OF OPERATION  |                        |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                             |   |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                        |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b><br>P.M. <input type="checkbox"/>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                        | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                        |  |  |   |   |   |   |   |
| ACTUAL SIGNATURE <b>A. M. France</b>  |                        |  | M.D.   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |
| EXAMINER'S NAME (Type) <b>A. M. FRANCE</b>  |                        |  |  |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |
|   |                        |  |  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |
|   |                        |  |  |   |   | ADDRESS (Street, city, town, or county)   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                        | 23b. DATE<br><b>Feb. 22, 1968</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Md.</b>                                       |   |   |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, 1050 York Road, Towson, Md. 21204</b>  |                        |  | ADDRESS  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 26 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b> |

78230

02330

0001 83 332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02350   |  |  |  |  |  |  |  |   |  |  |  | 02338   |  |  |  |  |  |  |  |                                |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--------------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |   |  |  |  | 02338   |  |  |  |  |  |  |  |                                |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  | 02338   |  |  |  |  |  |  |  |                                |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>DENNIS C. SHANAHAN</b>   |  |  |  |  |  | 20. DATE OF DEATH<br><b>Feb. 28, 1968</b>                            |  |   |  |  |  | 2b. HOUR<br><b>M</b>  |  |  |  |  |  |  |  |                                |  |  |  |
| 3. SEX<br><b>Male</b>   |  |  |  | 4. RACE<br><b>white</b>  |  |  |  | 5. DATE OF BIRTH<br><b>8/9/1904</b>   |  |  |  | 6. AGE (In years last birthday)<br><b>63</b> YRS.                                 |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b> Md.                                 |  |  |  |  |  |  |  |                                |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph's Hospital</b> |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Chief Inspector</b>   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Koppers Co.</b>                           |  |  |  |  |  |  |  |                                |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |  |  | 13c. CITY OR TOWN<br><b>Parkville</b>   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br><b>2817 Onyx Road</b>  |  |  |  |                                |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Patrick Shanahan</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Ann E. McCarthy</b> |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>no</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>213 01 5809</b>   |  |  |  | 17. INFORMANT<br><b>family</b> Address  |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>7341</b> IMMEDIATE CAUSE (a) <b>Systemic Lupus Erythematosus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>456x</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b>                   |  |  |  |  |  |  |  |                                |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Arteriosclerosis</b>  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |  |  |  |  |                                |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                 |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |                                |  |  |  |
| 22b. SIGNATURE<br><b>Darryl M. Robinson Jr.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  |  |  |  |   |  |  |  | 22c. DATE SIGNED<br><b>2/29/68</b>  |  |  |  |  |  |  |  |                                |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DARRYL M. ROBINSON JR.</b>   |  |  |  |  |  |  |  |   |  |  |  | 22e. ADDRESS<br><b>1209 St Paul St</b>  |  |  |  |  |  |  |  |                                |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 23b. DATE<br><b>3/2/1968</b>   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. John's, Long Green</b>   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                |  |  |  |  |  |  |  |                                |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>CHARLES F. EVANS &amp; SON</b> ADDRESS<br><b>8802 Harford Road</b>   |  |  |  |  |  |  |  |   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>MAR 4 1968</b>                                 |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |  |  |  |                                |  |  |  |

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

0330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |   |  |  |
|---|--|--|--|---|--|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |   |  |  |
| 023351  |  |  |  |   |  |   |  |   |  |  |
| 02339   |  |  |  |   |  |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Lloyd Middle Monroe Last Shipley   |   |  | 2a. DATE OF DEATH<br>Month February Day 6, Year 1968  |  | 2b. HOUR<br>9:00 a.m.                                   |  |  |
| 3. SEX<br>male  |  | 4. RACE<br>white   |  | 5. DATE OF BIRTH<br>1884 4-13   |  | 6. AGE (In years last birthday)<br>83 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>SPRING GROVE STATE HOSP. |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Farmer |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Kingsville  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br>Shipley Road 21087 |  |
| 14. FATHER'S NAME<br>First Benjamin Franklin Middle Shipley Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Henrietta Oales Middle Last  |   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>218-14-1052  |   | 17. INFORMANT<br>Address<br>Records: SPRING GROVE STATE HOSPITAL                     |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction, acute, death.<br>4109 DUE TO, OR AS A CONSEQUENCE OF with previous anteroseptal M.I.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) Arteriosclerotic Cardiovascular Mt. Dis. 3 yrs.<br>DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis, Generalized, senile. 10 yrs. |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 hr.   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Decubitus ulcers; chronic brain syndrome asso. with arteriosclerosis  |  |  |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State                      |   |  |   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from July 8, 1966, to Feb. 6, 1968, that (I) (we) last saw the deceased alive on Feb. 6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |   |  |  |
| 22b. SIGNATURE<br><i>Anthony J. Young</i>   |  |  |  |   |  | 22c. DATE SIGNED<br>2-6-68  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Anthony J. Young, M.D.  |  |  |  |   |  | 22e. ADDRESS<br>SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228                          |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>2-10-1968   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore City Md.                               |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Lassahn Funeral Home 7401 Belair Road  |  |  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 9 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Young</i>      |  |  |

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330

03330



FOR STATE  
HEALTH DEPT.

02352

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02340

|   |                         |  |   |   |   |   |  |                                   |
|---|-------------------------|--|---|---|---|---|--|-----------------------------------|
| 1. DECEASED-NAME<br>(Type or Print) <b>Joseph J. Sieber</b>   |                         |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Feb.</b> Day <b>3</b> Year <b>1968</b> |   |   | 2b. HOUR <b>7:25</b> M  |  |                                   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>March 21, 1889</b>                                    | 6. AGE (In years last birthday)<br><b>78</b> YRS  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS   | IF UNDER 24 HRS.<br>HOURS<br>MIN  | 2c. DATE PRONOUNCED DEAD<br>Month <b>Feb.</b> Day <b>3</b> Year <b>1968</b>   |  |                                   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |   | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Edgemere</b>  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7316 Bay Front Road</b>  |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><b>Foreman- Bethlehem Steel Co.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |                         |  | 13b. COUNTY <b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Edgemere</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               | 13e. STREET AND NUMBER<br><b>2201 Lincoln Ave.</b> |                                   |
| 14. FATHER'S NAME<br>First <b>Joseph</b> Middle <b>Sieber</b> Last <b>Sieber</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Barbara</b> Middle <b>Fuger</b> Last <b>Fuger</b>                      |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b> <b>WWI</b>                                   |  |                                   |
| 16b. SOCIAL SECURITY NO.<br><b>213-07-8974</b>  |                         |  | 17. INFORMANT (Son)<br><b>Mr. James T. Sieber, 2213 Firethorn Rd.</b>                                       |   |   | ADDRESS <b>Balto. Md.</b>   |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CH-5-C-V-Disease</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Security</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4221</b>                      |                         |  |   |   |   |   |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |                         |  |   |   |   |   |  |                                   |
| 19a. DATE OF OPERATION<br><b>4221</b>   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>None</b>  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |                                   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |  | County                            |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |   |   |   |   |  |                                   |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis</b>  |                         |  | M.D.  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>6800 Morningson Road</b>   |  |                                   |
| EXAMINER'S NAME (Type)<br><b>Melvin B. Davis</b>  |                         |  | M.D.  |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>22b. DATE SIGNED</b>   |  |                                   |
|   |                         |  |   |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dundalk, 2/3/68</b>  |  |                                   |
|   |                         |  |   |   |   | ADDRESS (Street, city, town, or county) <b>Md. 21222</b>  |  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>2/7/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |  |                                   |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>  |                         |  |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR<br><b>FEB 9 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE        |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.

necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03323

03340

Joseph

Robert

White

March 21, 1903

Joseph Robert

Robert

White

March 21, 1903

March 21, 1903

Joseph Robert

White

March 21, 1903

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME (Type or Print) <b>JACK NEVIN SIGA FOOSE</b>   |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>Feb</b> Day <b>17</b> Year <b>1968</b> |  |  |  |  |  |
| 3. SEX <b>M</b>   |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH <b>12-21-26</b>   |  | 6. AGE (In years last birthday) <b>41</b> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS HOURS MIN  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Illinois</b>   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>   |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bosley Ave</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Bar tender</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>   |  |  |  | 13b. COUNTY <b>Balto. Cockeysville</b>   |  |   |  | 13c. CITY OR TOWN <b>Cockeysville</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S-NAME First Middle Last <b>HARRY E. SIGA FOOSE</b>  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>KITTIE E. BRANDT</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes give war or dates of service) <b>WWII Korea</b>   |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>212-228040</b>  |  | 17. INFORMANT ADDRESS <b>Mrs Rita B. Sigafoose - Same as 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARBON MONOXIDE</b><br><b>9521</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HR.</b>                                 |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>9731</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)                             |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                   |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.   |  |  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>  |  |  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |  |  |
|   |  |  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |  |  |  |  |
|   |  |  |  |  |  | ADDRESS (Street, City, Town, or County) <b>Towson Ind 21204</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  |  |  | 23b. DATE <b>Feb 19, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE</b>  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Woodlawn Ind.</b>                           |  |
| 24. FUNERAL DIRECTOR <b>WM Cook-Brooks Towson</b>   |  |  |  | ADDRESS <b>1050 G ORIENTA Towson Ind 21204</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>FEB 20 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>  |  |

0537

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02354

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02342

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br>Charles G. Sillaman, Sr.   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>Feb. 4, 1968               |   |  | 2b. HOUR<br>3 A M   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>13 April 1910   |  | 6. AGE (In years last birthday)<br>57 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN     |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Forest Haven Nursing Home |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Ironworker - Ret.  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shipyard   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>AA   |   | 13c. CITY OR TOWN<br>Gambrills  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                       |  |
| 14. FATHER'S NAME<br>First Middle Last<br>David Sillaman  |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Elizabeth Farlow |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>no   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |   | 17. INFORMANT<br>Address<br>Gladys Sillaman, same as 13   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u><br><u>412.9</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ARROID SEVERE CARNI-UNSCUR</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>DISPNE</u><br>(c) <u>MULMURARY CHAMP-PLACUNNITIS</u> |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4221</u>   |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8/27</u> , 19 <u>67</u> , to <u>2/4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/31/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>John H. Shaw</u><br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |   | 22c. DATE SIGNED<br>5 Feb. 68   |  |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>John H. Shaw, M. D.   |  |   |   | 22e. ADDRESS<br>5800 Edmondson Ave. Balto. 21228  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>6 Feb. 68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Memorial Park  |  | 23d. LOCATION (City or Town) (County) (State)<br>Glen Burnie, Maryland                          |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Kirkley Funeral Home, Glen Burnie, Md.   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 7 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |

MEDICAL CERTIFICATION

0380



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02355   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02343  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| LOIS  |  |  |  |  |  |  |  |  |  | MAE  |  |  |  |  |  |  |  |  |  | SIMMONS  |  |  |  |  |  |  |  |  |  | Feb. Month 22, 1968 Year   |  |  |  |  |  |  |  |  |  | M                           |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| Female  |  |  |  |  |  |  |  |  |  | White  |  |  |  |  |  |  |  |  |  | January 12, 1902.  |  |  |  |  |  |  |  |  |  | 66 YRS.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  | USA  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | Md.                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Towson  |  |  |  |  |  |  |  |  |  | Chesapeake Manor Nursing Home  |  |  |  |  |  |  |  |  |  | Owner  |  |  |  |  |  |  |  |  |  | Restaurant   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 4503 Old Frederick Rd.      |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Robert  |  |  |  |  |  |  |  |  |  | Bloodsworth  |  |  |  |  |  |  |  |  |  | Unknown  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or, or unknown) (If yes give war or dates of service)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  |  |  |  |  |  | 219-03-6502  |  |  |  |  |  |  |  |  |  | Mr. Raymond Simmons  |  |  |  |  |  |  |  |  |  | (Same)   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a)   |  |  |  |  |  |  |  |  |  | Generalized Carcinomatosis   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 1538  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |  |  |  |  | (b) Carcinoma of Colon   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 1538  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 19, 1967, to Feb 21, 1968, that (I) (we) last saw the deceased alive on Feb 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Feb 22, 1968 2:30 AM. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| JAMSHID HAMED MD  |  |  |  |  |  |  |  |  |  | Feb 22, 1968.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| JAMSHID HAMED MD.   |  |  |  |  |  |  |  |  |  | TOWSON 4, MD.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  | 2/25/68.   |  |  |  |  |  |  |  |  |  | Asbury Cemetery  |  |  |  |  |  |  |  |  |  | Mt. Vernon, Md.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Leonard J. Ruck, Inc. Balto. Md. 21214  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | DATE FEB 23 1968   |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

73650

6483C

• 1007 •

gradually, gradually

• 2015/5/5

## Index

[illegible]

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |  |  |   |  |  |  |   |  |                                |  |
|---|--|--|--|---|--|--|--|---|--|--------------------------------|--|
| 02356   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 02344  |  |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>Clara   |  | Middle<br>E.  |  | Last<br>Simpler  |  | 2a. DATE OF DEATH<br>Month Day Year<br>Feb. 20 1968                         |  | 2b. HOUR<br>9: p M             |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>3-1-90  |  | 6. AGE (In years<br>last birthday)<br>77 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore<br>Randallstown, Md.                                 |  |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Balto. County Gen.              |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Clerk   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE 8<br>3721 Courtleigh Drive   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>3721 Courtleigh Drive                             |  |                                |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Jerome Williams   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Emma Dove   |  |   |  |  |  |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, na, or (unknown) (If yes give war or dates of service)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>219-16-4962  |  | 17. INFORMANT<br>Mr. W. G. Simpler - 3721 Courtleigh Drive<br>Randallstown, Md.   |  |  |  |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial insufficiency<br>4109<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201<br>DUE TO, OR AS A CONSEQUENCE OF (b) <del>ASCVD</del> Myocardial infarct (LV)<br>DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Terminal<br>Weeks-days<br>Months-YRS |  |  |  |   |  |  |  |   |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>Pulmonary atelectasis   |  |  |  |   |  |  |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? yes |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY<br>(AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                 |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |   |  |                                |  |
| 22b. SIGNATURE<br>Charles R. Paten. CO  |  | DEGREE   |  | ATTENDING<br>PHYS. <input type="checkbox"/>   |  | MED.<br>DIRECTOR <input type="checkbox"/>  |  | STAFF<br>PHYS. <input checked="" type="checkbox"/>                          |  | 22c. DATE SIGNED<br>2/20/68    |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>GP ACIB R. Paten. CO.  |  | 22e. ADDRESS   |  |   |  |  |  |   |  |                                |  |
| 23a. BURIAL-CREMATATION,<br>REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>2/23/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>WOODLAWN  |  | 23d. LOCATION (City or Town) (County) (State)<br>WOODLAWN, MD                        |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br>Loring Byers - 8728 Liberty Road  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 23 1968   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |   |  |                                |  |

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

03384

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02357  |  |                              |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                                    |   |  | 02345  |                                   |  |                  |
|--|--|------------------------------|--|---|------------------------------------|---|--|--|-----------------------------------|--|------------------|
| 1. DECEASED-NAME<br>(Type or print)  |  |                              |  | First   | Middle                             | Last  | 2a. DATE OF DEATH  |  |                                   | 2b. HOUR                                     |                  |
| Smith - Baby Boy   |  |                              |  |   |                                    |   | Month  | Day  | Year                              | 11:25 AM                                     |                  |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH  |                                    |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                   |  | IF UNDER 24 HRS. |
| Male   |  | Caucasian                    |  | Feb 5, 1968   |                                    |   | YRS.   |  | MONTHS                            | DAYS   | HOURS MIN.       |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |  |  |                                   |  |                  |
| Md.  |  | U.S.A.                       |  |   |                                    | BALTIMORE Md.   |  |  |                                   |  |                  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                  |
| BALTIMORE  |  |                              | G B M S  |   |                                    |   |  |  |                                   |  |                  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |                  |
| Md.  |  |                              | BALTO.   |   | BALTO.                             |   |  |  | 21212 1120 OVERBROOK Rd.          |  |                  |
| 14. FATHER'S NAME  |  |                              | 15. MOTHER'S MAIDEN NAME   |   |                                    |   |  |  |                                   |  |                  |
| First Middle Last  |  |                              | First Middle Last  |   |                                    |   |  |  |                                   |  |                  |
| Paul David Smith   |  |                              | Georgette Ruth Beverungen  |   |                                    |   |  |  |                                   |  |                  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address              |   |  |  |                                   |  |                  |
| Yes, no, or (unknown)  |  |                              |  |   | Mother's SHART                     |   |  |  |                                   |  |                  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |   |                                    |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                  |
| PART I. DEATH WAS CAUSED BY:   |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| IMMEDIATE CAUSE (a) Immaturity   |  |                              |  |   |                                    |   |  |  |                                   | 10 hours                                     |                  |
| 777X DUE TO, OR AS A CONSEQUENCE OF  |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| (c)  |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| 776X 30 weeks gestation  |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |                                    | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                   |  |                  |
|  |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY  |   |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |                                   |  |                  |
|  |  |                              | HOUR A.M. Month Day Year P.M. 19   |   |                                    |   |  |  |                                   |  |                  |
| 21d. INJURY OCCURRED   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |  |  |                                   |  |                  |
| White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-5-68 11:30 AM to 2-5-68 11:30 PM, that (I) (we) lost the deceased alive on 2-5-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |   |                                    |   |  |  |                                   |  |                  |
| 22b. SIGNATURE   |  |                              | 22c. DATE SIGNED   |   |                                    |   |  |  |                                   |  |                  |
| HL Rodriguez   |  |                              | 2-5-68   |   |                                    |   |  |  |                                   |  |                  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              | 22e. ADDRESS   |   |                                    |   |  |  |                                   |  |                  |
|  |  |                              | Guta Baltimore Med. Center   |   |                                    |   |  |  |                                   |  |                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |  |                  |
| Cremation  |  |                              | 2/9/68   |   | G B M C                            |   | Towson, Md. 21204  |  |                                   |  |                  |
| 24. FUNERAL DIRECTOR   |  |                              | 25a. REC'D BY REGISTRAR  |   |                                    | 25b. REGISTRAR'S SIGNATURE  |  |  |                                   |  |                  |
| John E. Adams  |  |                              | G B M C  |   |                                    | FEB 13 1968   |  |  |                                   |  |                  |

03322

03322

03322

03322



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |   |  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br><b>AUGUSTA</b>  |  | Middle<br><b>VIRGINIA</b>   |  | Last<br><b>SMITH</b>  |  | 2c. DATE OF DEATH<br>Month <b>February</b> Day <b>2</b> Year <b>1968</b>         |  | 2b. HOUR<br><b>11:40 P</b>                               |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br><b>October 9, 1882</b>  |  | 6. AGE (In years last birthday)<br><b>85</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>—</b> DAYS <b>—</b>                                 |  | IF UNDER 24 HRS.<br>HOURS <b>—</b> MIN. <b>—</b>         |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson 4</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Joseph Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>At Home</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>3616 Milford Avenue-21207</b>                       |  |  |
| 14. FATHER'S NAME First<br><b>—</b>   |  | Middle<br><b>—</b>   |  | Last<br><b>PRIESTER</b>   |  | 15. MOTHER'S MAIDEN NAME First<br><b>UNKNOWN</b>  |  | Middle<br><b>—</b>   |  | Last<br><b>—</b>   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>—</b>   |  | 17. INFORMANT<br><b>Helen S. Harden</b>   |  | Address<br><b>2703 Beethoven Ave #7</b>   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br><b>410.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>—</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>—</b> |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>—</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201 Pulmonary thromboembolism</b>   |  |  |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>—</b> |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>—</b>   |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>—</b>                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>—</b>  |  |   |  |  |  |  |
| 22a. I certify that <b>10</b> (this hospital) attended the deceased from <b>February 2, 1968</b> , to <b>February 2, 1968</b> , that <b>we</b> last saw the deceased alive on <b>February 2, 1968</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>10</b> (we) (did) (did not) view the body after death.                 |  |  |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>William</b>  |  | DEGREE<br><b>—</b>   |  | ATTENDING PHYS.<br><input type="checkbox"/>   |  | MED. DIRECTOR<br><input type="checkbox"/>   |  | STAFF PHYS.<br><input checked="" type="checkbox"/>                               |  | 22c. DATE SIGNED<br><b>February 2, 1968</b>              |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Ines Gilliani M. D.</b>  |  | 22e. ADDRESS<br><b>7620 York Road, Towson 4, Maryland</b>  |  |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>2-5-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT OLIVET Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                              |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Ellsworth Armacost</b>   |  | ADDRESS<br><b>4600 Lib. Heights Ave</b>  |  | 25a. REC'D BY REGISTRAR<br><b>—</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>—</b>  |  | DATE<br><b>5 1968</b>  |  |  |

MEDICAL CERTIFICATION

1915

JANUARY

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02359   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02347  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| First Helen Middle Grove Last Smith   |  |  |  |  |  |  |  |  |  | Month 2 Day 25 Year 68   |  |  |  |  |  |  |  |  |  | 1 PM   |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  | 4. RACE  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  | IF UNDER 1 YEAR  |  |  |  |  | IF UNDER 24 HRS.                  |  |  |  |  |  |  |  |  |  |
| Female  |  |  |  |  | White  |  |  |  |  | 6/11/83  |  |  |  |  | 84 YRS.  |  |  |  |  | MONTHS   |  |  |  |  | DAYS                              |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  | United States  |  |  |  |  |  |  |  |  |  | Baltimore Md.  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |  |  |  |  |  |  |
| Lutherville   |  |  |  |  | College Manor Nursing Home   |  |  |  |  |  |  |  |  |  | Housewife  |  |  |  |  |  |  |  |  |  | Own Home                          |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  | 13b. COUNTY  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER   |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  | Baltimore  |  |  |  |  | City   |  |  |  |  |  |  |  |  |  | Apt. 3339 N Charles St.  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| First Ferdinand Middle - Last Focke   |  |  |  |  |  |  |  |  |  | First Rachel Middle - Last Lehman  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| No  |  |  |  |  |  |  |  |  |  | 214-38-7356  |  |  |  |  |  |  |  |  |  | Louise Smith Cockey Address 1407 Charmuth Rd. Lutherville, Md. 21093 |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  | Cerebrovascular, general   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | (b) DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |  |  | 4500   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1949, 19 to Feb, 1968, that (I) (we) last saw the deceased alive on Feb 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  | 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| W. G. Helfrich MD   |  |  |  |  | 2-26-68  |  |  |  |  | Dr. William G. Helfrich  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 22e. ADDRESS  |  |  |  |  | 22f. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 5006 Roland Ave.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  | 2/27/68  |  |  |  |  | Druid Ridge  |  |  |  |  | Pikesville, Balto. Co. Md.   |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |
| H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.  |  |  |  |  | DATE FEB 26 1968   |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                   |  |  |  |  |  |  |  |  |  |

03323

03323

CERTIFICATE OF MARRIAGE

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

On the \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

\_\_\_\_\_ and \_\_\_\_\_

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02360

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02348

|   |                         |   |   |   |   |   |  |  |
|---|-------------------------|---|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Nannie A. Smith</b>  |                         |   | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <b>2-27-1968</b> |   |   | 2b. HOUR <b>10</b> M  |  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>July 8, 1900</b>         | 6. AGE (in years last birthday)<br><b>67</b> YRS  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  | IF UNDER 24 HRS<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD<br>Month <b>2</b> Day <b>29</b> Year <b>1968</b>                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Edgemere</b>  |                         |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>2600 Brannan Ave.</b>                                      |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |                         |   | 13b. COUNTY <b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Edgemere</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             | 13e. STREET AND NUMBER<br><b>2600 Brannan Ave.</b> |  |
| 14. FATHER'S NAME<br>First <b>Thomas</b> Middle <b>F.</b> Last <b>Martin</b>  |                         |   | 15. MOTHER'S MAIDEN NAME<br>First <b>Jennie</b> Middle <b>V.</b> Last <b>?</b>  |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>                             |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>2/</b>   |                         |   | 17. INFORMANT (Daughter)<br><b>Mrs. Myrtle L. Robinson,</b>   |   |   | ADDRESS <b>Balto. Md. 21219 Waldman Ave.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>A-S-C-V- Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |                         |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>   |                         |   |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                         |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         |   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.  |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK  |                         |   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |   |   |   |   |   |  |  |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis</b>  |                         |   | M.D.  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>6800 Morningson Rd.</b>                                  |  |  |
| EXAMINER'S NAME (Type)  |                         |   | M. D.   |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>3/1/68</b>   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         |   | 23b. DATE<br><b>3/4/67</b>  |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda,</b>  |                         |   | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>   |   |   | 25a. REC'D BY REGISTRAR<br><b>MAR 4 1968</b>  |  |  |
|   |                         |   |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Jones</b>  |  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |                         |   |   |   |   |   |  |  |

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300

02300



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-1-1-1-1  
30M REV. 1-7-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |  |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |  |  |   |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |   |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First<br>SARAH   |  | Middle<br>ELIZABETH   |  | Last<br>SPARKS  |  | 2a. DATE OF DEATH<br>FEBRUARY 28, 1968   |  | 2b. HOUR<br>12:05 AM  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>December 31, 1884   |  | 6. AGE (In years last birthday)<br>83 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Presbyterian Home of Md. |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>None |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |   |  |
| 14. FATHER'S NAME First Middle Last<br>John Wesley Sparks  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Mary Malvina Way  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) No  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br>Presbyterian Home of Md. Towson, Md  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CEREBRAL ARTERIOSCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 month<br>9 YRS. |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>333X ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                             |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |  | State   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>60</u> , to <u>FEB 28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>FEB 21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                  |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Dr. S.J. Venable, Jr.</u>   |  |  |  |   |  | DEGREE<br>M.D.  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2-28-68                                       |  |
| 22d. PHYSICIAN'S NAME (Type)<br>Dr. S.J. Venable, Jr.  |  |  |  |   |  | 22e. ADDRESS<br>7215 York Rd. Baltimore, Md.  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>3-1-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oaklawn   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |  |  |   |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Mitchell-Wiedefeld Home, Inc.<br>6500 York Rd. Baltimore, Md. 21212  |  |  |  |   |  | 25a. RECEIVED BY REGISTRAR<br>FEB 29 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |

13344

OFFICE OF DEATH

02830

DATE OF DEATH: JANUARY 24, 1904

PLACE OF DEATH: NEW YORK

NAME OF DECEASED: [illegible]

RESIDENCE: [illegible]

CAUSE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF MARRIAGE: [illegible]

NAME OF SPOUSE: [illegible]

DATE OF INTERMENT: [illegible]

PLACE OF INTERMENT: [illegible]

NAME OF FUNERAL HOME: [illegible]

DATE OF DEATH: [illegible]

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |                              |  |  |                                    |   |      |  |  |  |         |
|---|---------|------------------------------|--|--|------------------------------------|---|------|--|--|--|---------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |                              |  |  |                                    |   |      |  |  |  |         |
| 1. DECEASED-NAME<br>(Type or Print)   |         |                              | First Middle Last  |  |                                    | 2a. DATE KNOWN OF DEATH   |      |  | 2b. HOUR   |  |         |
| John M. B. Spilman  |         |                              |  |  |                                    | 2/2/1968  |      |  | 8:30 AM  |  |         |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR  |                                    | IF UNDER 24 HRS   |      | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR   |         |
| Male  | White   | 4/1/1902                     | 65 YRS.  | MONTHS   | DAYS                               | HOURS   | MIN. | 2 Month 2 Day  | Year 1968  |  | 8:30 AM |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |      |  |  |  |         |
| Maryland  |         | U.S.A.                       |  |  |                                    | Baltimore Md.   |      |  |  |  |         |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |      |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |         |
| Baltimore County  |         |                              | St. Joseph's Hospital  |  |                                    | Lighting salesman   |      |  | Lighting   |  |         |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN   |      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER                                 |         |
| Maryland  |         |                              |  |  |                                    | Baltimore   |      | YES  |  | 746 E. Lake Avenue                                     |         |
| 14. FATHER'S NAME First Middle Last   |         |                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |                                    |   |      |  |  |  |         |
| Jeremiah Spilman  |         |                              | Alice Brooks   |  |                                    |   |      |  |  |  |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                              | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT ADDRESS   |      |  |  |  |         |
| No  |         |                              | 215-09-8704  |  |                                    | Mrs. Margaret J. Spilman 746 E. Lake Ave.   |      |  |  |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |                              |  |  |                                    |   |      |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4201   |         |                              |  |  |                                    |   |      |  |  |  |         |
| 19a. DATE OF OPERATION  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |                                    |   |      |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |         |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                 |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |  |  |  |         |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |      |  |  |  |         |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                              |  |  |                                    |   |      |  |  |  |         |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)  |         |                              | M.D.   |  |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |      |  | 22b. DATE SIGNED<br>2/2/68   |  |         |
| Charles F. O'Donnell  |         |                              |  |  |                                    | ADDRESS (Street, city, town, or county)   |      |  |  |  |         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   |      | 23d. LOCATION (City or Town) (County) (State)  |  |  |         |
| Burial  |         |                              | 2/5/1968   |  | New Cathedral Cemetery             |   |      | Baltimore, Maryland  |  |  |         |
| 24. FUNERAL DIRECTOR ADDRESS  |         |                              |  |  |                                    | 25a. REC'D BY REGISTRAR   |      | 25b. REGISTRAR'S SIGNATURE   |  |  |         |
| John A. Moran Inc. 3000 E. Baltimore Street   |         |                              |  |  |                                    | FEB 5 1968  |      | Charles Judge  |  |  |         |

03300

RECEIVED

03300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |      |   |   |   |                                       |  |  |
|--|--|--|---|--|--|---|------|---|---|---|---------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |      |   |   |   |                                       |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |      |   |   |   |                                       |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First   |  | Middle   |   | Last |   | 2a. DATE OF DEATH<br>Month Day Year   |   | 2b. HOUR<br>8:55am                    |  |  |
| Marlin   |  |  | Starnor   |  | February   |   | 24   |   | 1968  |   |                                       |  |  |
| 3. SEX<br>Male   |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>September 6, 1922   |      |   | 6. AGE (In years<br>last birthday)<br>45 YRS.   |   |                                       | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (State or foreign<br>country) Pennsylvania  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   | 9. COUNTY OF DEATH<br>Towson, Baltimore 4 Md.   |   |                                       |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) St. Joseph Hospital |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |      |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |                                       |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE Maryland  |  |  | 13b. COUNTY Baltimore   |  |  | 13c. CITY OR TOWN   |      |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |                                       | 13e. STREET AND NUMBER<br>2840 Louisiana Avenue-27 |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Oscar T Starnor  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Esta Dittenhafer                                      |  |  |   |      |   |   |   |                                       |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) Yes   |  |  | (If yes give war or dates of service) WW II   |  |  | 16b. SOCIAL SECURITY NO.  |      |   | 17. INFORMANT<br>Family   |   |                                       | Address<br>Same                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chronic renal failure and severe anemia<br>582X DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause last.<br>xxx with terminal heart failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |      |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |                                       |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>593X  |  |  |   |  |  |   |      |   |   |   |                                       |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?   |   |                                       |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |      |   |   |   |                                       |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                     |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |      |   |   |   |                                       |  |  |
| 22a. I certify that (a) (this hospital) attended the deceased from February 17, 1968, to February 24, 1968, that (b) (we) last saw the deceased alive on February 24, 1968, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |      |   |   |   |                                       |  |  |
| 22b. SIGNATURE<br>Ines Cilliani, M. D.   |  |  |   |  |  |   |      |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>February 24, 1968 |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)  |  |  | 22e. ADDRESS<br>7620 York Road, Towson 4, Md.   |  |  |   |      |   |   |   |                                       |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE<br>2/27/68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Haven Cem |   |      | 23d. LOCATION (City or Town) (County) (State)<br>Glen Burnie AA Co Md |   |   |                                       |  |  |
| 24. FUNERAL DIRECTOR<br>Mc Lully F.H. 737 Fatasco Ave  |  |  | ADDRESS<br>21275  |  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 27 1968   |      |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |                                       |  |  |

2230

03363

0301 12 1973



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 02364  |  |   |  |  |  | 02352  |  |  |  |   |  |
| 1. DECEASED-NAME (Type or print) First <u>Esther</u> Middle <u>NMI</u> Last <u>STEIN</u>   |  |   |  |  |  | 2a. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>68</u>                                 |  |  |  | 2b. HOUR <u>5:50 AM</u>                             |  |
| 3. SEX <u>FEMALE</u>   |  | 4. RACE <u>WHITE</u>  |  | 5. DATE OF BIRTH <u>1-1-93</u>   |  | 6. AGE (In years last birthday) <u>75</u> YRS.   |  | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>                          |  | IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>         |  |
| 7a. BIRTHPLACE (State or foreign country) <u>PENNA</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <u>BALTO.</u> Md.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <u>Randallstown</u>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give Street address) <u>BALTO. CO. GEN. HOSP.</u> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>HOUSEWIFE</u>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>   |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>PENNA</u>   |  | 13b. COUNTY <u>Phila.</u>   |  | 13c. CITY OR TOWN <u>Phila.</u>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <u>6201 N. 15th ST.</u>                       |  |   |  |
| 14. FATHER'S NAME First <u>Abraham</u> Middle <u></u> Last <u>DAVID</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME First <u>ANNA</u> Middle <u></u> Last <u>Schwartz</u>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <u></u> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO. <u>181-38-0799</u>   |  | 17. INFORMANT <u>MRS. BETTY NATHAN</u> Address <u>3402 STEVENSWOOD CT. #21207</u>  |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>563.1 GASTRO-INTESTINAL BLEEDING</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ULCERATIVE COLITIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>572.2</u>   |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. <u>19</u> Month <u></u> Day <u></u> Year <u></u> P.M. <u></u>               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |  | 21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>   |  |  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN. 20, 1968</u> , to <u>FEB. 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>FEB. 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |  |  |  |  |   |  |
| 22b. SIGNATURE <u>Fausto Q. Aquino, Jr.</u> DEGREE <u></u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |  |  | 22c. DATE SIGNED <u>2-3-68</u>                      |  |
| 22d. PHYSICIAN'S NAME (Type) <u>FAUSTO Q. AQUINO JR.</u>   |  |   |  |  |  |  |  |  |  | 22e. ADDRESS <u>C/O BALTIMORE COUNTY GEN. HOSP.</u> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE <u>2-4-68</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>ROOSEVELT</u>  |  | 23d. LOCATION (City or Town) (County) (State) <u>PHILADELPHIA, PENNSYLVANIA</u>              |  |  |  |   |  |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>   |  |   |  | 25a. REC'D BY REGISTRAR <u>FEB 6 1968</u> DATE   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>                                     |  |  |  |   |  |

03384

OFFICE OF THE  
ATTORNEY GENERAL

03384

|  |  |
|--|--|
| STATE OF NEW YORK                                |  |
| IN SENATE  |  |
| JANUARY 10, 1910                                 |  |
| REPORT   |  |
| OF THE   |  |
| COMMISSIONERS OF THE LAND OFFICE                 |  |
| IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE |  |
| MAY 1, 1909                                      |  |
| ALBANY:  |  |
| J. B. LEECH, PRINTER.                            |  |
| 1910.  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>02365</div> <div> <div>02353</div> <div>02353</div> </div>   |  |  |   |  |                                   |  |  |  |   |  |  |
|---|--|--|---|--|-----------------------------------|--|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) <b>WILLIAM DAVID STEVENS</b>   |  |  |   |  |                                   | 2a. DATE OF DEATH<br>Month <b>FEB</b> Day <b>8</b> Year <b>1968</b>  |  |  | 2b. HOUR <b>3:30 PM</b>                               |  |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>   |   | 5. DATE OF BIRTH <b>12-22-91</b>   |                                   |  | 6. AGE (In years lost birthday) <b>76</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <b>76</b> DAYS <b>76</b>       |  | IF UNDER 24 HRS. HOURS <b>76</b> MIN.        |
| 7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>                                    |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                   | 9. COUNTY OF DEATH <b>Baltimore County</b> Md.   |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>Mount Wilson</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Mt. Wilson State Hospital</b> |  |                                   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>FARMER</b>                                   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b> |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>   |  |  | 13b. COUNTY <b>HARFORD</b>  |  | 13c. CITY OR TOWN <b>ABINGDON</b> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>Box 396 SINGER RD.</b>      |  |  |
| 14. FATHER'S NAME First <b>WILLIAM R.</b> Middle <b>STEVENSON</b> Last <b>STEVENSON</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First <b>IDA</b> Middle <b>SCHAFER</b> Last <b>SCHAFER</b>  |                                   |  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>no</b>   |  |  |   | 16b. SOCIAL SECURITY NO. <b>212-14-9334</b>  |                                   | 17. INFORMANT Address <b>Records, Mt. Wilson State Hospital</b>  |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>491X</b><br>IMMEDIATE CAUSE (a) <b>Cor Pulmonale, decompensated</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pulmonary Emphysema &amp; Fibrosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>5221</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |                                   |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Perianal abscess</b>  |  |  |   |  |                                   |  |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |                                   | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                   |  |  |  |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   |  |                                   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>1-12-1967</b> to <b>2-2-1968</b> , that (I) (we) lost the deceased on <b>2-2-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |                                   |  |  |  |   |  |  |
| 22b. SIGNATURE <b>W Newcomer</b>  |  |  |   |  |                                   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED <b>Feb. 8, 1968</b>                                 |   |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>  |  |  |   |  |                                   | 22e. ADDRESS <b>Mount Wilson, Maryland</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>Feb. 11, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>   |                                   |  | 23d. LOCATION (City or Town) <b>Emmorton</b> (County) <b>Harford</b> (State) <b>Md.</b>      |  |   |  |  |
| 24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son</b> ADDRESS <b>Abingdon, Maryland</b>   |  |  |   |  |                                   | 25a. REC'D BY REGISTRAR <b>FEB 13 1968</b> DATE  |  | 25b. REGISTRAR'S SIGNATURE   |   |  |  |

12222

MINO TO SHIMIZU

02362

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| <div>02366</div> <div> <div>MD</div> <div>02354</div> </div>  |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  |   |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|---------|--|------------------|---|---------------------------------|--|---|--|---|--|---|--|--------------------|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  | 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH |   | 6. AGE (In years last birthday) |  | 7a. BIRTHPLACE (State or foreign country) |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH |  |  |  |  |  |  |  |  |  |  |
| Philip A. Stewart   |  |  |  |  | male   |  | Negro   |  | March 12, 1878   |   | 89 YRS.                         |  | Md.                                       |  | U. S.   |  |   |  | Baltimore Md.      |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |         |  |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| Catonsville   |  |  |  |  | SPRING GROVE STATE HOSP.   |  |         |  |                  | Laborer   |                                 |  |   |  | hwy. dept.  |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  | 13b. COUNTY  |  |         |  |                  | 13c. CITY OR TOWN   |                                 |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |                    | 13e. STREET AND NUMBER                       |  |  |  |  |  |  |  |  |  |
| Md.   |  |  |  |  | Prince George's  |  |         |  |                  | Cedar Hgts.   |                                 |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                          |  |   |  |                    | 931 - 63rd Ave.                              |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |         |  |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown                        |                                 |  |   |  | 16b. SOCIAL SECURITY NO.  |  |   |  |                    | 17. INFORMANT Address                        |  |  |  |  |  |  |  |  |  |
| William Stewart   |  |  |  |  | Carmelia Meredith  |  |         |  |                  | No  |                                 |  |   |  | 579-30-2265   |  |   |  |                    | Records: SPRING GROVE STATE HOSPITAL         |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |         |  |                  | undeter.  |                                 |  |   |  |   |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |         |  |                  | IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, organism                               |                                 |  |   |  |   |  |   |  |                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |  |  |  |  |  |  |  |
| 485X  |  |  |  |  |  |  |         |  |                  | DUE TO, OR AS A CONSEQUENCE OF  |                                 |  |   |  |   |  |   |  |                    | 3 days.                                      |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491X   |  |  |  |  |  |  |         |  |                  | (b) DUE TO, OR AS A CONSEQUENCE OF  |                                 |  |   |  |   |  |   |  |                    | (c)  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  |   |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| Arteriosclerotic cardiovascular Ht. Dis., with CVA 1958   |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  |   |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |         |  |                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                  |                                 |  |   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |         |  |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)         |                                 |  |   |  |   |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |         |  |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                 |  |   |  |   |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from Aug. 17, 1967, to Feb. 5, 1968, that (X) (we) last saw the deceased alive on Feb. 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  |   |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  | 22c. DATE SIGNED  |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| Anthony J. Young, M.D.  |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  | 2-5-68  |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  | 22e. ADDRESS  |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| Anthony J. Young, M.D.  |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  | SPRING GROVE STATE HOSPITAL<br>Baltimore, Maryland 21228                          |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  | 23b. DATE  |  |         |  |                  | 23c. NAME OF CEMETERY OR CREMATORY  |                                 |  |   |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| BURIAL  |  |  |  |  | 2-10-68  |  |         |  |                  | Harmony   |                                 |  |   |  | Highland Park Md  |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  | 25a. REC'D BY REGISTRAR   |  |   |  |                    | 25b. REGISTRAR'S SIGNATURE                   |  |  |  |  |  |  |  |  |  |
| H.S. Washington 45-4925 D.C. 1/1/68   |  |  |  |  |  |  |         |  |                  |   |                                 |  |   |  | DATE FEB 14 1968  |  |   |  |                    |  |  |  |  |  |  |  |  |  |  |

05380

05380

DECLARATION OF DEATH

DECLARATION OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |   |  |                                |  |
|---|--|---|--|---|--|--|--|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |  |  |   |  |                                |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First   |  | Middle  |  | Last   |  | 2a. DATE OF DEATH<br>Month Day Year                                     |  | 2b. HOUR                       |  |
| Clara Cornell   |  | Stout   |  |   |  |  |  | February 19, 1968   |  | 6:30 AM                        |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (In years<br>last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| Female  |  | White   |  | Feb. 12, 1882   |  | 86 YRS.  |  |   |  |                                |  |
| 7a. BIRTHPLACE (State or foreign<br>country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |   |  |                                |  |
| New Jersey  |  | U.S.A.  |  |   |  | Baltimore Md.  |  |   |  |                                |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |   |  |                                |  |
| Reisterstown  |  | Old Hanover Rd.   |  | Housewife   |  | ---  |  |   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET AND NUMBER  |  |                                |  |
| Maryland  |  | Baltimore   |  | Reisterstown  |  |  |  | Old Hanover Rd.   |  |                                |  |
| 14. FATHER'S NAME   |  | First   |  | Middle  |  | Last   |  | 15. MOTHER'S MAIDEN NAME  |  | First Middle Last              |  |
|   |  | Sidell  |  |   |  |  |  | Sarah   |  | Hardy                          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address   |  |  |  |   |  |                                |  |
| No  |  | 579-66-2150   |  | Mrs. Vera Kerwin Old Hanover Rd.,<br>Reis. Md.  |  |  |  |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerosis - generalized</u><br>4409 DUE TO, OR AS A CONSEQUENCE OF -<br>(b) <u>Pneumonia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <u>2 months</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |  |  |   |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4500  |  |   |  |   |  |  |  |   |  |                                |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>September 1967</u> , to <u>February 1968</u> , that (I) (we) last<br>saw the deceased alive on <u>February 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |                                |  |
| 22b. SIGNATURE<br><u>Clarence E. McWilliam</u>  |  |   |  |   |  | DEGREE ATTENDING<br>PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br>2-19-68   |  |                                |  |
| 22d. PHYSICIAN'S<br>NAME (Type)   |  |   |  |   |  | 22e. ADDRESS<br>11904 Reisterstown Rd Reisterstown Md.   |  |   |  |                                |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |   |  |                                |  |
| Burial  |  | Feb. 21, 1968   |  | Harleigh Cemetery   |  | Camden, New Jersey   |  |   |  |                                |  |
| 24. FUNERAL DIRECTOR<br><u>H. J. Ehlhardt</u>   |  |   |  |   |  | ADDRESS<br>Owings Mills, Md.   |  | 25a. RECEIVED BY REGISTRAR<br>FEB 21 1968                               |  |                                |  |
|   |  |   |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                        |  |                                |  |

02307

CERTIFICATE OF DEATH

02307

10-20-66  
 Clara Corbett  
 8304

10-13-66  
 White  
 Female

10-13-66  
 U.S.A.  
 New Jersey

10-13-66  
 Old Manor Rd.  
 Balaclava

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

10-13-66  
 Balaclava  
 Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M. REV. 1/68

| <div style="display: flex; justify-content: space-between;"> <span>02368</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>02356</span> </div>   |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Lillian</b>   |  |   |  | First <b>E.</b> Middle <b>Strauss</b> Last  |  |   |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>8</b> Year <b>1968</b> |  |  | 2b. HOUR<br><b>6:20</b> AM                                     |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>August 10, 1888</b>  |  |   | 6. AGE (In years last birthday)<br><b>79</b> YRS.                      |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>               |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Bloomsbury Retreat Convl. Home</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  | 13e. STREET AND NUMBER<br><b>54 Avalon Avenue</b>                        |  |  |  |
| 14. FATHER'S NAME First <b>William</b> Middle <b>Coale</b> Last  |  |   |  | 15. MOTHER'S MAIDEN NAME First <b>Wood</b> Middle <b>Wood</b> Last  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT (Daughter)<br><b>Mrs. Anna Marie Fry, 54 Avalon Ave. Dundalk,</b>   |  |   |  | Address <b>Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC C-V DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 YRS.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4221 ACUTE INFECTIOUS INFECTION</b>  |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> , 19 <b>66</b> , to <b>2/8</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Paul R. Ziegler</b>   |  | 22c. DATE SIGNED<br><b>2/8/68</b>   |  | 22d. PHYSICIAN'S NAME (Type) <b>Paul R. Ziegler</b> M. D. 22e. ADDRESS <b>200 Chesnut Hill Dr. Ellicott City, Md.</b>                                       |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>2/10/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>   |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 13 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |  |  |

WSES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |   |  |                                |  |  |  |
|--|--|--|--|---|--|---|--|--------------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |  |   |  |                                |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |                                |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH              |  | 2b. HOUR                                     |  |
| George W. Strober  |  |  |  |   |  |   |  | Feb. Month 29 Day 1968         |  | 3:55 AM                                      |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                |  | IF UNDER 24 HRS.                             |  |
| M  |  | W  |  | 7/4/1900  |  | 67 YRS.   |  | MONTHS                         |  | DAYS   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                |  |  |  |
|  |  |  |  |   |  | Baltimore Md.   |  |                                |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                |  |  |  |
| Baltimore 21227  |  | Caton Ridge N. H.  |  |   |  |   |  |                                |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER         |  |  |  |
| Maryland   |  | BALTIMORE  |  |   |  |   |  | Owings Mills Barnes Ave. 21117 |  |  |  |
| 14. FATHER'S NAME  |  | First  |  | Middle  |  | Last  |  | 15. MOTHER'S MAIDEN NAME       |  | First Middle Last                            |  |
|  |  |  |  |   |  |   |  |                                |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  | (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address   |  |                                |  |  |  |
|  |  |  |  |   |  |   |  |                                |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |   |  |                                |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(R) upper lobe pneumonia</u>   |  |  |  |   |  |   |  |                                |  | 1 week                                       |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cong. Heart Failure</u>   |  |  |  |   |  |   |  |                                |  | 2 weeks                                      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.S.C.V.D.</u>  |  |  |  |   |  |   |  |                                |  | month  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |   |  |                                |  |  |  |
| 4221 <u>malnutrition</u>   |  |  |  |   |  |   |  |                                |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |                                |  |  |  |
|  |  |  |  |   |  |   |  |                                |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |                                |  |  |  |
|  |  | 19   |  |   |  |   |  |                                |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County                         |  | State  |  |
|  |  |  |  |   |  |   |  |                                |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>23 Feb</u> , 19 <u>68</u> , to <u>29 Feb</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>23 Feb</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |                                |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYS.   |  | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |  | 22c. DATE SIGNED               |  |  |  |
| <u>Ralph E. Updike</u>   |  |  |  | <input checked="" type="checkbox"/>   |  |   |  | <u>29 Feb 68</u>               |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |   |  |   |  |                                |  |  |  |
| <u>Ralph E. Updike</u>   |  | <u>3, Dogwood Drive 21043</u>  |  |   |  |   |  |                                |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town)  |  | (County)                       |  | (State)                                      |  |
| <u>Removal</u>   |  | <u>Feb 29, 1968</u>  |  | <u>St. Anthony's</u>  |  | <u>BALTIMORE</u>  |  | <u>Md.</u>                     |  |  |  |
| 24. FUNERAL DIRECTOR   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |  |                                |  |  |  |
| <u>Frank H. Newell</u>   |  | <u>1400 N. E. St.</u>  |  | <u>MAR 1 1968</u>   |  | <u>Charles Judge</u>  |  |                                |  |  |  |

0.2634



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                     |  |   |  |  |  |  |   |  |  |
|---|--|-------------------------------------|--|---|--|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                                     |  |   |  |  |  |  |   |  |  |
| CERTIFICATE OF DEATH  |  |                                     |  |   |  |  |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |                                     |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |  |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Arbutus</b>  |  |                                     |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Arbutus</b>   |  |  |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>903 Maiden Choice Lane</b>   |  |                                     |  |   |  | d. STREET ADDRESS<br><b>903 Maiden Choice Lane</b>   |  |  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VIOLA</b> Middle <b>ELIZABETH</b> Last <b>SULLIVAN</b>  |  |                                     |  |   |  | 4. DATE OF DEATH<br>Month <b>2</b> Day <b>24</b> Year <b>1968</b>  |  |  |   |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Color</b>    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | B. DATE OF BIRTH<br><b>1/2/1903</b>  |  | 9. AGE (In years last birthday)<br><b>65</b> yrs.                      |   | IF UNDER 1 YEAR<br>Months Days Hours Min.          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |  |  |
| 13. FATHER'S NAME<br><b>Henry Knight</b>  |  |                                     |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Abendschoen</b>   |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |                                     |  | 16. SOCIAL SECURITY NO.<br><b>212-03-6554</b>   |  | 17. INFORMANT<br>Address <b>Joseph Sullivan (Husband) As Above</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b><br><b>4129</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                     |  |   |  |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b> sudden</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |  |                                     |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                   |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4/19, 1968</b> , to <b>2/24, 1968</b> , that (I) (we) last saw the deceased alive on <b>2/24, 1968</b> , and that death occurred at <b>5:00 PM</b> , from causes and on the date stated above.   |  |                                     |  |   |  |  |  |  |   |  |  |
| 22a. SIGNATURE<br><b>James N. Frederick</b>   |  |                                     |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  | 22b. DATE SIGNED<br><b>4/25/68</b>                                     |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James N. Frederick</b>   |  |                                     |  |   |  | 22d. ADDRESS<br><b>1311 Francis Ave. Balto. Md 21227</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>2/28/68</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Raymond C. Fink</b>  |  |                                     |  |   |  | ADDRESS<br><b>Glen Burnie, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 28 1968</b>                     |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

023370

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 02371  |         |  |  |  |                 |   |                 |   |                              | 02359  |          |  |  |          |  |  |  |  |  |
|--|---------|--|--|--|-----------------|---|-----------------|---|------------------------------|--|----------|--|--|----------|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |         |  |  |  |                 |   |                 |   |                              | MEDICAL EXAMINER'S CERTIFICATE OF DEATH          |          |  |  |          |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  |  | Middle   |                 | Last  |                 | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year   |                              | 2b. HOUR   |          | 2c. DATE OF ESTI-<br>DEATH MATED <input type="checkbox"/> Feb. 3, 1968 |  | 2d. HOUR |  |  |  |  |  |
| JOSEPH   |         | S.   |  | SWEET Sr.  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR |   | IF UNDER 24 HRS |   | 2c. DATE PRONOUNCED DEAD     |  | 2d. HOUR |  |  |          |  |  |  |  |  |
| Male   | White   | Jan. 4, 1926   |  | 42 YRS.  | MONTHS DAYS     |   | HOURS MIN.      |   | Month Feb. Day 3, Year 19 68 |  | 12:45    |  |  |          |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |                 | 9. COUNTY OF DEATH  |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| Maryland   |         | U. S. A.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                     |                 | Baltimore   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) |                 | 12b. KIND OF BUSINESS OR INDUSTRY                                   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| Dundalk  |         | 2814 Southbrook Rd   |  | Electrician - Local #24  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |  | 13c. CITY OR TOWN  |                 | 13d. INSIDE CITY LIMITS?  |                 | 13e. STREET AND NUMBER  |                              |  |          |  |  |          |  |  |  |  |  |
| Maryland   |         | Baltimore  |  | Dundalk  |                 | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                 | 2814 Southbrook Road  |                              |  |          |  |  |          |  |  |  |  |  |
| 14. FATHER'S NAME  |         | First  |  | Middle   |                 | Last  |                 | 15. MOTHER'S MAIDEN NAME  |                              | First  |          | Middle   |  | Last     |  |  |  |  |  |
| Thomas   |         |  |  |  |                 | Sweet   |                 | Annie   |                              |  |          |  |  | Herman   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (Wife)   |                 | ADDRESS   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| Yes  |         | WWII   |  | 219-18-8052  |                 | Mrs. Marguerite Sweet, 2814 Southbrook Rd.                          |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |  |  |  |                 |   |                 |   |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH     |          |  |  |          |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| IMMEDIATE CAUSE (a) Lobar Pneumonia  |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 481X DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| (c) DUE TO, OR AS A CONSEQUENCE OF   |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 490X   |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                      |                 |   |                 | 20. AUTOPSY?  |                              |  |          |  |  |          |  |  |  |  |  |
|  |         |  |  |  |                 |   |                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                              |  |          |  |  |          |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>  |         | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)        |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| CAUSE OF DEATH   |         | HOUR A.M. P.M. 19  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.   |                 | City or Town  |                 | County  |                              | State  |          |  |  |          |  |  |  |  |  |
|  |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |                 |   |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| ACTUAL SIGNATURE   |         | Werner U. Spitz, M.D.  |  |  |                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                     |                 | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>      |                              | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |          | 22b. DATE SIGNED 2-4-68  |  |          |  |  |  |  |  |
| EXAMINER'S NAME (Type)   |         |  |  |  |                 | ADDRESS (Street, city, town, or county)                             |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |                 | 23d. LOCATION (City or Town) (County) (State)                       |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| Burial   |         | 2/7/68   |  | Sacred Heart of Jesus Cem.   |                 | Baltimore, Md.  |                 |   |                              |  |          |  |  |          |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |         |  |  | ADDRESS  |                 |   |                 | 25a. REC'D BY REGISTRAR   |                              | 25b. REGISTRAR'S SIGNATURE                       |          |  |  |          |  |  |  |  |  |
| John J. Duda, 7922 Wise Ave. Dundalk, Md.  |         |  |  |  |                 |   |                 | FEB 7 1968  |                              | Charles Judge                                    |          |  |  |          |  |  |  |  |  |

05859

05371

05371

05371

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |         |                              |  |  |   |   |   |                                   |  |  |
|---|--|---------|------------------------------|--|--|---|---|---|-----------------------------------|--|--|
| 02372   |  |         |                              |  | 02350  |   |   |   |                                   |  |  |
| 1. DECEASED-NAME (Type or print)  |  |         |                              |  | 2a. DATE OF DEATH  |   |   | 2b. HOUR  |                                   |  |  |
| Richard Talbott   |  |         |                              |  | Feb 16 1968  |   |   | 10:30 M   |                                   |  |  |
| 3. SEX  |  | 4. RACE |                              | 5. DATE OF BIRTH   |  |   | 6. AGE (In years lost birthday)   |   | IF UNDER 1 YEAR MONTHS DAYS       |  |  |
| Male  |  | White   |                              | 10-13-1876   |  |   | 91 YRS.   |   |                                   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |                                   |  |  |
| Maryland  |  |         | U.S.A.                       |  |  |   | BALTIMORE COUNTY Md.  |   |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| CATONSVILLE   |  |         |                              | Summit Nursing Home  |  |   | OWNER - LUMBER YARD   |   | LUMBER                            |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |         |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |                                   | 13e. STREET AND NUMBER   |  |
| Md.   |  |         |                              | Howard   |  | Elliott City  |   | YES   |                                   | 127 Church Road  |  |
| 14. FATHER'S NAME First Middle Last   |  |         |                              | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |   |   |                                   |  |  |
| Edward A. Talbott   |  |         |                              | Georgiana LANEY  |  |   |   |   |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |  |         |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   | Address   |                                   |  |  |
| ?   |  |         |                              | ?  |  | Barbara Fisher  |   | 101 Columbia Rd. Elliott City, Md.  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |         |                              |  |  |   |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                         |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>   |  |         |                              |  |  |   |   |   |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocardial Disease</u>  |  |         |                              |  |  |   |   |   |                                   | 4 yrs.   |  |
| (c) <u>Atherosclerotic Cardiovascular Disease</u>   |  |         |                              |  |  |   |   |   |                                   | 5 yrs.   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |         |                              |  |  |   |   |   |                                   |  |  |
| 4221  |  |         |                              |  |  |   |   |   |                                   |  |  |
| 19a. DATE OF OPERATION  |  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |         |                              |  |  |   |   |   |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |         |                              | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |   |                                   |  |  |
|   |  |         |                              |  |  |   |   |   |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |         |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town  |                                   | County State   |  |
|   |  |         |                              |  |  |   |   |   |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1960, to <u>2-16</u> , 1968, that (I) (we) last saw the deceased alive on <u>2-15</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |                              |  |  |   |   |   |                                   |  |  |
| 22b. SIGNATURE <u>Thomas F. Herbert, M.D.</u>   |  |         |                              |  |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED <u>2-16-68</u>                                      |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>   |  |         |                              |  |  | 22e. ADDRESS <u>44 Church Rd. Elliott City, Md 21043</u>                        |   |   |                                   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |         | 23b. DATE                    |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |   | 23d. LOCATION (City or Town) (County) (State)   |                                   |  |  |
| Burial  |  |         | 2-19-68                      |  | St Johns   |   |   | Elliott City Howard Md.   |                                   |  |  |
| 24. FUNERAL DIRECTOR <u>Higginbotham-Slack</u>  |  |         |                              |  |  | ADDRESS <u>Elliott City, Md.</u>  |   | 25a. REC'D BY REGISTRAR DATE <u>FEB 21 1968</u>   |                                   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                      |  |

MEDICAL CERTIFICATION

02030

UNITED STATES OF AMERICA

02030

1. Name of the vessel: *U.S.S. Albatross*

2. Date of departure: *10/1/1892*

3. Name of the commanding officer: *John A. King*

4. Name of the observer: *John A. King*

5. Name of the vessel's home port: *San Francisco*

6. Name of the vessel's destination: *Alaska*

7. Name of the vessel's commanding officer: *John A. King*

8. Name of the vessel's observer: *John A. King*

9. Name of the vessel's home port: *San Francisco*

10. Name of the vessel's destination: *Alaska*

11. Name of the vessel's commanding officer: *John A. King*

12. Name of the vessel's observer: *John A. King*

13. Name of the vessel's home port: *San Francisco*

14. Name of the vessel's destination: *Alaska*

15. Name of the vessel's commanding officer: *John A. King*

16. Name of the vessel's observer: *John A. King*

17. Name of the vessel's home port: *San Francisco*

18. Name of the vessel's destination: *Alaska*

19. Name of the vessel's commanding officer: *John A. King*

20. Name of the vessel's observer: *John A. King*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |                  |  |
|---|--|--|--|--|--|---|--|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |                  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  |                  | 2b. HOUR                                     |
| Anna  |  |  | Brown Taylor   |  |  | Month 2 Day 20 Year 68 9:22 a M   |  |                  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  |   | 6. AGE (In years last birthday)  |                  | IF UNDER 1 YEAR                              |
| Female  |  | Cau  |  | Jan. 19, 1886  |  |   | 82   |                  | MONTHS DAYS HOURS MIN.                       |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                  |  |
| Maryland  |  | U.S.A.   |  |  |  | Baltimore Md.   |  |                  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |                  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Baltimore   |  |  | Greater Baltimore Medical Center   |  |  | Housewife   |  |                  | Home   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?   |                  | 13e. STREET AND NUMBER                       |
| Maryland  |  |  | Baltimore  |  | Monkton  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                 |                  | Corbett and Matthews Roads                   |
| 14. FATHER'S NAME First Middle Last   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last   |  |   |  |                  |  |
| Charles M. Brown  |  |  |  | Julia Coleman  |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |  |                  |  |
|   |  |  |  |  |  | A. Frederick Taylor, Monkton, Md.   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4129<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |  |  |   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |                  |  |
| 4221  |  |  |  |  |  |   |  |                  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)  |   |  |                  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20, 19 68, to 2/20/19 68, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.     |  |  |  |  |  |   |  |                  |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   |  | 22c. DATE SIGNED |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  | 22e. ADDRESS   |   |  |                  |  |
| R. Breiteneker, M.D.  |  |  |  |  | 6701 N. Charles Street   |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                  |  |
| BURIAL  |  | Feb. 22, 1968  |  | Darlington   |  | Darlington, Maryland  |  |                  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                  |  |
| Wm. Cook-Brooks Towson, 1050 York Rd. Towson Maryland   |  |  |  |  | FEB 23 1968  |   |  |                  |  |

12380

STATE OF OHIO

6331

IN SENATE,  
JANUARY 1, 1903.  
REPORT  
OF THE  
COMMISSIONER OF THE  
BUREAU OF REVENUE,  
FOR THE YEAR  
ENDING DECEMBER 31, 1902.  
COLUMBUS, OHIO:  
THE STATE PRINTING OFFICE,  
1903.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

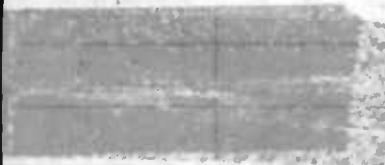
VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |   |   |  |                            |  |
|--|--|--|--|---|---|---|---|--|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |   |   |  |                            |  |
| CERTIFICATE OF DEATH   |  |  |  |   |   |   |   |  |                            |  |
| 02374  |  |  |  |   |   |   |   |  |                            |  |
| 02362  |  |  |  |   |   |   |   |  |                            |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |   | 2b. HOUR                                 |                            |  |
| JAMES  |  |  | TAYLOR   |   |   | February 18, 1968   |   | 4:30 PM                                  |                            |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |                            |  |
| male   |  | Negro  |  | 10/6/1895   |   | 72 YRS.   |   |  |                            |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |   |  |                            |  |
| Virginia   |  | U. S. A.   |  |   |   | Baltimore County, Md.   |   |  |                            |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY        |                            |  |
| Mount Wilson   |  |  | Mt. Wilson State Hosp.   |   |   | Sawmill worker  |   |  |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  | 13e. STREET AND NUMBER     |  |
| MD   |  |  | Caroline   |   | Denton  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 5th Street                 |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |   |  |                            |  |
| First Middle Last  |  |  | First Middle Last  |   |   |   |   |  |                            |  |
| Unknown  |  |  | Ophelia TAYLOR   |   |   |   |   |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |   |   |  |                            |  |
| Unknown  |  |  | Unknown  |   | Records, Mt. Wilson State Hospital  |   |   |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |   |   |   |  |                            |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |   |   |   |   |  |                            |  |
| IMMEDIATE CAUSE (a) Tuberculous Meningitis   |  |  |  |   |   |   |   |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |   |  |                            |  |
| (b) Pulmonary Tuberculosis   |  |  |  |   |   |   |   |  |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |   |   |   |   |  |                            |  |
| (c)  |  |  |  |   |   |   |   |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |   |   |   |  |                            |  |
| 0021   |  |  |  |   |   |   |   |  |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |                            |  |
| HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |   |   |   |   |  |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |                            |  |
|  |  |  |  |   |   |   |   |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/14/1968, to 2/18/1968, that (I) (we) last saw the deceased alive on 2/18/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |   |   |  |                            |  |
| 22b. SIGNATURE   |  |  |  |   | DEGREE  |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED           |  |
| William Newcomer   |  |  |  |   |   |   |   |  | 2/18/68                    |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |   | 22e. ADDRESS  |   |   |  |                            |  |
| William Newcomer, M.D.   |  |  |  |   | Mount Wilson, Md.   |   |   |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)   |   |  |                            |  |
| REMOVAL  |  | 2-21-1968  |  | SPRING GROVE CEMETERY   |   | Denton, Caroline Md.  |   |  |                            |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   | ADDRESS   |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE |  |
| Charles W. Hill, Mortician,  |  |  |  |   | Denton, Md.   |   | DATE Feb 21 1968  |  | Charles J. ...             |  |

03285

RECEIVED

03285



RECEIVED  
FEB 11 1964  
U.S. DEPARTMENT OF  
COMMERCE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |                                    |  |      |   |  |  |  |
|---|--|--|--|--|------------------------------------|--|------|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |                                    |  |      |   |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |                                    |  |      |   |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First  |  | Middle                             |  | Last |   | 2a. DATE OF DEATH  |  |  |
| Anna  |  |  | L.   |  | Thomas                             |  |      |   | Month Day Year<br>Feb. 12 1968   |  |  |
| 3. SEX  |  |  | 4. RACE  |  | 5. DATE OF BIRTH                   |  |      | 6. AGE (In years last birthday)               |  | 7b. HOUR                                     |  |
| Female  |  |  | White  |  | July 4 1882                        |  |      | 85 YRS.                                       |  | 12:10p                                       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                                    | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |      |   | 9. COUNTY OF DEATH   |  |  |
| Missouri  |  |  | U.S.A.   |  |                                    |  |      |   | Baltimore Md.  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |      |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Catonsville   |  |  | House in the Pines   |  |                                    | Housewife  |      |   | none   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  |                                    | 13c. CITY OR TOWN  |      |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| Maryland  |  |  | Baltimore  |  |                                    | rural Balto  |      |   | 7320 Windsor Mill Rd.  |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |                                    |  |      |   |  |  |  |
| First Middle Last   |  |  | First Middle Last  |  |                                    |  |      |   |  |  |  |
| Unknown   |  |  | Maria  |  |                                    |  |      |   | Eichhorn   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  |                                    | 17. INFORMANT  |      |   | Address  |  |  |
| no  |  |  | 213-34-2899  |  |                                    | Marguerite Leutner   |      |   | 7320 Windsor Mill Rd 7   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |                                    |  |      |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |                                    |  |      |   |  |  |  |
| IMMEDIATE CAUSE (a) <u>myocardial insufficiency</u>   |  |  |  |  |                                    |  |      |   |  | 12hr   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u>  |  |  |  |  |                                    |  |      |   |  | 15yr.  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |                                    |  |      |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |                                    |  |      |   |  |  |  |
| 4221  |  |  |  |  |                                    |  |      |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |      |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
|   |  |  |  |  |                                    |  |      |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |      |   |  |  |  |
|   |  |  |  |  |                                    |  |      |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State   |      |   |  |  |  |
|   |  |  |  |  |                                    |  |      |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-24, 1964, to 2-12, 1968, that (I) (we) last saw the deceased alive on 2-12-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |                                    |  |      |   |  |  |  |
| 22b. SIGNATURE <u>Wilmer K. Gallagher, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  |                                    |  |      |   |  |  |  |
| 22c. DATE SIGNED 2-12-68  |  |  |  |  |                                    |  |      |   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, M.D.</u> 22e. ADDRESS <u>6209 Frederick Ave. Balt. Md. 21228</u>   |  |  |  |  |                                    |  |      |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |  |      | 23d. LOCATION (City or Town) (County) (State) |  |  |  |
| Burial  |  |  | 2/15/68  |  | Lorraine Cemetery                  |  |      | Woodlawn Balto co Md.                         |  |  |  |
| 24. FUNERAL DIRECTOR <u>Horing Byers</u> 8728 Liberty Rd. Randallstown Md.  |  |  |  |  |                                    |  |      |   |  |  |  |
| 25a. REC'D BY REGISTRAR <u>FEB 16 1968</u> DATE   |  |  |  |  |                                    | 25b. REGISTRAR'S SIGNATURE <u>Charles Y...</u>   |      |   |  |  |  |

CASE

CSRS



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02376

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02364

|  |                         |  |   |  |  |
|--|-------------------------|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Rita Florence Thompson</b>  |                         |  | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month <b>2</b> Day <b>2</b> Year <b>1968</b> 2b. HOUR <b>00</b> M <b>A</b> |  |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>2/14/19</b>   | 6. AGE (in years and birthday)<br><b>48</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>                                 | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>   |
| 7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>  |                         |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><b>Abbutus</b>  |                         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1711 Park Avenue</b>                          |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |                         |  | 13b. COUNTY <b>Baltimore</b>  | 13c. CITY OR TOWN <b>Arbutus</b>   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 14. FATHER'S NAME<br><b>Bruce Clarke</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br><b>Elizabeth Flood</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                         |  | 16b. SOCIAL SECURITY NO.<br><b>161-0907263</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Aubrey G. Thompson 1711 Park Avenue</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br><b>953 X</b> IMMEDIATE CAUSE (a) <b>Asphyxia by Hanging - Self Inflicted</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |                         |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>974 X</b>  |                         |  |   |  |  |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.             |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                     |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |   |  |  |
| ACTUAL SIGNATURE <b>James N. Frederick</b>   |                         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |   | 22b. DATE SIGNED <b>2/2/68</b>   |  |
| EXAMINER'S NAME (Type) <b>James N. Frederick, M.D.</b>   |                         | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                          |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                      |  |
|  |                         | ADDRESS (Street, city, town, or county) <b>1311 Francis Avenue</b>           |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                         | 23b. DATE <b>2-5-1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>                    |  |
| 24. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>   |                         | ADDRESS <b>21229</b>   |   | 25a. REC'D BY REGISTRAR <b>FEB 5 1968</b>  |  |
|  |                         |  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                  |  |

059

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Dr. D.P. Caplan authorizes me to prepare this certificate.*

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |  |  |   |   |  |
|--|--|--|---|---|--|--|--|---|---|--|
| 02377  |  |  |   |   | 02365  |  |  |   |   |  |
| 1. DECEASED-NAME (Type or print) <b>RICHARD HAROLD TRAINOR Sr.</b>   |  |  |   |   | 2a. DATE OF DEATH <b>February 4, 1968</b>                        |  |  | 2b. HOUR <b>10P M</b>   |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>                       |   | 5. DATE OF BIRTH <b>Oct. 9, 1900</b>  |  |  | 6. AGE (In years last birthday) <b>67</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS                                |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Pikesville</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>320 Upland Rd. Pikesville</b> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Postman</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Mail</b>                            |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>  |  |  | 13b. COUNTY <b>Baltimore</b>  |   | 13c. CITY OR TOWN <b>Pikesville</b>                              |  | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER <b>320 Upland Road</b>                 |  |
| 14. FATHER'S NAME First <b>Patrick</b> Middle <b>Trainor</b> Last <b>Trainor</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>G.</b> Last <b>Lynch</b>   |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <b>Yes</b>   |  |  | 16b. SOCIAL SECURITY NO. <b>WWI 1917-18 215-03-5665</b>   |   | 17. INFORMANT Address <b>Richard H. Trainor, Jr. Upperco, Md</b> |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma, stomach</b><br><b>151.9</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>151X</b>  |  |  |   |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?          |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.   |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                        |  |   |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4 Feb., 1968</b> , to <b>4 Feb., 1968</b> , that (I) (we) lost the deceased alive on <b>4 Feb., 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |   |   |  |  |  |   |   |  |
| 22b. SIGNATURE <b>Charles H. Williams M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |   |  |  |  | 22c. DATE SIGNED  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>Charles H. Williams M.D.</b>   |  |  |   |   | 22e. ADDRESS <b>Pikesville, Md. 21208</b>                        |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  | 23b. DATE <b>2/7/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>      |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Woodlawn, Balto. Co. Md.</b> |   |  |
| 24. FUNERAL DIRECTOR <b>A. J. Schhardt</b> ADDRESS <b>Owings Mills, Md.</b>  |  |  |   |   | 25a. REC'D BY REGISTRAR <b>FEB 7 1968</b>                        |  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                               |   |  |

2280

15

0001 0 100 10

自來水

451

1997

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

011242

•

170

Copyright © 1999 by John Wiley & Sons, Inc.

Woodbury, New York

...all in all...

4. 2. 2. 2.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| Item 18 Film 398 2-19-68 MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Dorothy</b>  |  |  | First <b>A.</b> Middle <b>T</b> Last <b>TUTTLE</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>February</b> Day <b>19</b> Year <b>1968</b>   |  |  | 2b. HOUR <b>11:40</b> P. M.  |  |  |
| 3. SEX<br><b>Female</b>   |  |  | 4. RACE<br><b>White</b>  |  |  | 5. DATE OF BIRTH<br><b>June 27, 1914</b>  |  |  | 6. AGE (In years lost birthday)<br><b>53</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore,</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. JOSEPH HOSPITAL</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Homemaker</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET AND NUMBER<br><b>8910 Lennings Lane</b>   |  |  | 14. FATHER'S NAME First <b>Leo F.</b> Middle <b>Gall</b> Last <b></b>                                      |  |  | 15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>Hatten</b> Last <b>Field</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>No.</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>214-03-4308</b>   |  |  | 17. INFORMANT<br><b>Clyde S. Hill</b>   |  |  | Address<br><b>1711 Northview Road.</b>   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis</b><br><b>174 X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma-left breast</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>170 X</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/30/</b> , 19 <b>68</b> , to <b>2/19/</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>2/19/</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>William A. Rogers, M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  |  |   |  |  | 22c. DATE SIGNED<br><b>February 19, 1968</b>   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>William A. Rogers, M.D.</b>  |  |  | 22e. ADDRESS<br><b>815 Eastern Ave., Baltimore, Md. 21221</b>  |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Feb. 22, 1968</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br><b>Philip E. Crach</b>  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 23 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |

7.7880

4254



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 7/68

Item#1Film#G397 2/15/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

02367

|   |  |  |                |  |   |   |  |                        |              |  |        |                            |  |
|---|--|--|----------------|--|---|---|--|------------------------|--------------|--|--------|----------------------------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  | First  | Middle (Bates) | Last   | 2a. DATE OF DEATH   |   | 2b. HOUR   |                        |              |  |        |                            |  |
| H E L E N A   |  | A.   |                | U M B A C H  | Feb. 6, 1968  |   | 2:45am   |                        |              |  |        |                            |  |
| 3. SEX  |  | 4. RACE  |                | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)                                     |  | IF UNDER 1 YEAR        |              | IF UNDER 24 HRS.                             |        |                            |  |
| female  |  | white  |                | November 5, 1880.  |   | 87 YRS.   |  | MONTHS                 |              | DAYS   |        |                            |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |                | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                        |              |  |        |                            |  |
| Penna.  |  | USA  |                |  |   | Baltimore   |  | Md.                    |              |  |        |                            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |                | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                        |              |  |        |                            |  |
| Towson  |  | Chesapeake Manor   |                | Housewife  |   |   |  |                        |              |  |        |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  | 13b. COUNTY  |                | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER |              |  |        |                            |  |
| Md.   |  | Balto.   |                | Balto.   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 1641 Myones            |              |  |        |                            |  |
| 14. FATHER'S NAME   |  | First  | Middle         | Last   | 15. MOTHER'S MAIDEN NAME  |   | First  | Middle                 | Last         |  |        |                            |  |
| John  |  |  |                | Bates  | ?   |   |  |                        | Oyler        |  |        |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> or unknown <input type="checkbox"/>  |  | 16b. SOCIAL SECURITY NO.   |                | 17. INFORMANT  |   | Address   |  |                        |              |  |        |                            |  |
| None  |  | None   |                | Mrs. Ida Hollander   |   | (Same)  |  |                        |              |  |        |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |                |  |   |   |  |                        |              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |        |                            |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |                |  |   |   |  |                        |              |  |        |                            |  |
| IMMEDIATE CAUSE (a) <u>404x</u> <u>Coronary arteriosclerosis</u>  |  |  |                |  |   |   |  |                        |              | 5 yrs.                                       |        |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiovascular disease</u>  |  |  |                |  |   |   |  |                        |              | 20 yrs.                                      |        |                            |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>last.</u>   |  |  |                |  |   |   |  |                        |              |  |        |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |                |  |   |   |  |                        |              |  |        |                            |  |
| 442X  |  |  |                |  |   |   |  |                        |              |  |        |                            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |                |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                        |              |  |        |                            |  |
|   |  |  |                |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |  |                        |              |  |        |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |                |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |                        |              |  |        |                            |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |                |  |   |   |  |                        |              |  |        |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |                |  | 21f. LOCATION   |   | Street or R.F.D. No.   |                        | City or Town |  | County |                            |  |
|   |  |  |                |  |   |   |  |                        |              |  |        |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 5, 1968</u> to <u>Feb. 6, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 5, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |                |  |   |   |  |                        |              |  |        |                            |  |
| 22b. SIGNATURE  |  |  |                |  |   |   |  |                        |              | 22c. DATE SIGNED                             |        |                            |  |
| Dr. A. M. Bacon, M.D.   |  |  |                |  |   |   |  |                        |              | 2/6/68.                                      |        |                            |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |                |  |   |   |  |                        |              | 22e. ADDRESS                                 |        |                            |  |
| Dr. A. M. Bacon   |  |  |                |  |   |   |  |                        |              | 2810 Taylor Avenue, Balto.-34                |        |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |                | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town)  |  | (County)               |              | (State)                                      |        |                            |  |
| Burial  |  | 2/9/68.  |                | Parkwood Cemetery  |   | Baltimore, Md.  |  |                        |              |  |        |                            |  |
| 24. FUNERAL DIRECTOR  |  |  |                |  |   |   |  |                        |              | 25a. REC'D BY REGISTRAR                      |        | 25b. REGISTRAR'S SIGNATURE |  |
| Leonard J. Ruck, Inc.-Balto., Md...14   |  |  |                |  |   |   |  |                        |              | DATE FEB - 8 1968                            |        | [Signature]                |  |

05373

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

Item 12a, 13b, 13c, 13d  
Film G398 3/4/68 ap  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02368

|  |  |  |        |   |   |  |  |   |                                      |
|--|--|--|--------|---|---|--|--|---|--------------------------------------|
| 1. DECEASED NAME<br>(Type or print) <i>Joseph</i>  |  | First <i>Joseph</i>  | Middle | Last <i>Vain</i>  | 2a. DATE OF DEATH<br>Month <i>2</i> Day <i>12</i> Year <i>68</i>                |  | 2b. HOUR<br><i>8:15 P</i>  |   |                                      |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>  |        | 5. DATE OF BIRTH<br><i>12-23-1891</i>   |   | 6. AGE (In years last birthday)<br><i>76</i> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |                                      |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Austria</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Baltimore</i>   |  |   | Md.                                  |
| 10. CITY OR TOWN OF DEATH<br><i>Garrison</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Foxliegh Nursing Home</i> |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Statewide Tailor</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>men's clothing</i>                           |  |   |                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md</i>   |  | 13b. COUNTY<br><i>Baltimore</i>  |        | 13c. CITY OR TOWN<br><i>Pikesville</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>11331 Reisterstown Rd.</i>   |                                      |
| 14. FATHER'S NAME<br>First <i>Francis</i> Middle <i>Zyta</i> Last <i>Height</i>  |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Catherine</i> Middle <i>Zyputa</i> Last <i>Ferry Rd.</i>                |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <i>no</i> (If yes give war and dates of service)  |   | 16b. SOCIAL SECURITY NO.<br><i>215-03-7095</i>                                       |  | 17. INFORMANT<br><i>Margaret V. Williams - Pikesville, Md.</i>  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinoma, lung</i><br>1621 DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>12 months</i> |  |  |        |   |   |  |  |   |                                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>1638</i>  |  |  |        |   |   |  |  |   |                                      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                                      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |        |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |  |  |   |                                      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |        |   | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State                 |  |  |   |                                      |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9 Oct</i> , 19 <i>32</i> , to <i>12 Feb</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10 Feb</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |        |   |   |  |  |   |                                      |
| 22b. SIGNATURE<br><i>Charles H. Williams MD</i>  |  |  |        |   |   | DEGREE<br><i>MD</i>  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                      |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Charles H. Williams MD</i>  |  |  |        |   |   | 22e. ADDRESS<br><i>Pikesville 8, Md.</i>   |  |   | 22c. DATE SIGNED<br><i>12 Feb 68</i> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>15 Feb 1968</i>  |        | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Glenn Haven Memorial Pk</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Glenn Haven Md.</i>              |  |   |                                      |
| 24. FUNERAL DIRECTOR<br><i>Singleton</i>   |  |  |        | ADDRESS<br><i>Singleton Funeral Home / Pikesville</i>   |   | 25a. REC'D BY REGISTRAR<br>DATE <i>FEB 14 1968</i>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Jones</i>   |                                      |

03280

ORIGINATOR OF RECORD

03280

RECORDS SECTION, U.S. DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATION, WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02381   |  |  |  |  |  |  |  |  |  | 02369   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  |  |  | First<br>CATHERINE   |  |  |  |  | Middle<br>M.  |  |  |  |  | Last<br>VAN SANT   |  |  |  |  | 2a. DATE OF DEATH<br>February 9 Day 1968           |  |  |  |  | 2b. HOUR<br>7:35 PM            |  |  |  |  |
| 3. SEX<br>Female  |  |  |  |  | 4. RACE<br>White   |  |  |  |  | 5. DATE OF BIRTH<br>December 10, 1887   |  |  |  |  | 6. AGE (In years<br>last birthday)<br>80 YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |  |  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>W. Va.  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>St. Joseph Hospital |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Housewife   |  |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland  |  |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 13e. STREET AND NUMBER<br>8303 Avondale Rd., 21234 |  |  |  |  |                                |  |  |  |  |
| 14. FATHER'S NAME<br>First<br>John  |  |  |  |  | Middle<br>Corrigan   |  |  |  |  | Last<br>Mary  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>First<br>Mary  |  |  |  |  | Middle<br>Philbin                                  |  |  |  |  | Last                           |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  | 17. INFORMANT<br>Mr. Irving H. Van Sant, 861 Park Ave. 21201  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |                                |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u><br>433.9<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last.<br>(b) <u>C.V.A., Cerebral Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>C.V.A., Cerebral Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH    |  |  |  |  |                                |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>332 X   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                        |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>January 30 1968</u> , to <u>February 9, 1968</u> , that (I) (we) last<br>saw the deceased alive on <u>February 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 22b. SIGNATURE<br><u>Alexis S. Sayoc M.D.</u> DEGREE  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br>2/9/68                         |  |  |  |  |                                |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Alexis S. Sayoc, M.D.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br>7620 York Rd., Towson, Md.   |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  |  |  | 23b. DATE<br>2/12/68.  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holy Redeemer Cemetery  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.  |  |  |  |  |  |  |  |  |  |                                |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Leonard J. Ruck, Inc. Balto. Md. 21214  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE 13 1968  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u> |  |  |  |  |                                |  |  |  |  |

7230

4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 02382  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02370  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Emma   |  |  |  |  |  |  |  |  |  | Vogt   |  |  |  |  |  |  |  |  |  | Feb. 9, 1968   |  |  |  |  |  |  |  |  |  | 7:45 PM  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 3. SEX   |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN |  |  |  |  |  |  |  |  |  |
| Female   |  |  |  |  |  |  |  |  |  | Caucasian  |  |  |  |  |  |  |  |  |  | Oct. 13, 1878  |  |  |  |  |  |  |  |  |  | 89 YRS.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  | Md.                        |  |  |  |  |  |  |  |  |  |
| Germany  |  |  |  |  |  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Catonsville  |  |  |  |  |  |  |  |  |  | Forest Haven Nursing Home  |  |  |  |  |  |  |  |  |  | Housewife  |  |  |  |  |  |  |  |  |  | Home   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Maryland   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Baltimore  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 1829 Duncan St. 21213       |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Adam   |  |  |  |  |  |  |  |  |  | Gutberlet  |  |  |  |  |  |  |  |  |  | Theresa  |  |  |  |  |  |  |  |  |  | Eckstein   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| No   |  |  |  |  |  |  |  |  |  | 212-26-8848  |  |  |  |  |  |  |  |  |  | Nick Bordes  |  |  |  |  |  |  |  |  |  | 933 Cromwell Bridge Rd.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |  |  |  |  | PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 4/29   |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a) A.S.G.U.D.   |  |  |  |  |  |  |  |  |  | years  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |  |  |  |  | 4221   |  |  |  |  |  |  |  |  |  | None   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 Feb, 1968, to 9 Feb, 1968, that (I) (we) last saw the deceased alive on 9 Feb, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Ralph E. Updike M.D.   |  |  |  |  |  |  |  |  |  | 11 Feb 68  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Ralph E. Updike M.D.   |  |  |  |  |  |  |  |  |  | 31 Dogwood Dr. (21043)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| Burial   |  |  |  |  |  |  |  |  |  | 2/12/1968  |  |  |  |  |  |  |  |  |  | Moreland Memorial  |  |  |  |  |  |  |  |  |  | Baltimore County, Maryland   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. RECD BY REGISTRAR   |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |
| William E. Johnson   |  |  |  |  |  |  |  |  |  | 8521 Loch Raven Blvd, 21204  |  |  |  |  |  |  |  |  |  | FEB 14 1968  |  |  |  |  |  |  |  |  |  | Charles Judge  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                            |  |  |  |  |  |  |  |  |  |

03388

03388

UNITED STATES

1968

1968

Oct. 15, 1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |   |  |   |  |   |   |                             |  |
|---|--|--|---|---|--|---|--|---|---|-----------------------------|--|
| CERTIFICATE OF DEATH  |  |  |   |   |  |   |  |   |   |                             |  |
| 1. DECEASED-NAME (Type or print) <u>Charles H Wagner</u>  |  |  |   |   |  | 2a. DATE OF DEATH <u>Month 2 Day 22 Year 1968</u>                                       |  |   | 2b. HOUR <u>M</u>                             |                             |  |
| 3. SEX <u>Male</u>  |  | 4. RACE <u>White</u>   |   | 5. DATE OF BIRTH <u>Aug 16-1897</u>   |  | 6. AGE (In years last birthday) <u>70</u> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS                     |   | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country) <u>MD</u>   |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                      |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <u>BALTIMORE</u> Md.   |  |   |   |                             |  |
| 10. CITY OR TOWN OF DEATH <u>Parkville</u>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>2001 Taylor Ave</u> |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY             |                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>   |  |  | 13b. COUNTY <u>BALTO</u>  |   | 13c. CITY OR TOWN <u>Parkville</u>                                     |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER <u>2001 Taylor Ave</u> |                             |  |
| 14. FATHER'S NAME First <u>Henry</u> Middle <u>Wagner</u> Last  |  |  |   | 15. MOTHER'S MAIDEN NAME First <u>Marion</u> Middle <u>Snelling</u> Last <u>Same</u>  |  |   |  |   |   |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)  |  |  |   | 16b. SOCIAL SECURITY NO. <u>412-09-4699</u>   |  | 17. INFORMANT <u>Marion Snelling</u>  |  |   | Address <u>Same</u>                           |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RIGHT MIDDLE CEREBRAL ARTERY THROMBOSIS</u><br><u>4339</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ARTERIOSCLEROSIS</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 WKS</u><br><u>10 YRS</u> |  |  |   |   |  |   |  |   |   |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>332X</u>   |  |  |   |   |  |   |  |   |   |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |   |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |   |                             |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |   |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>52</u> , to <u>2/22</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>2/22</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |   |  |   |   |                             |  |
| 22b. SIGNATURE <u>L.P. Bergen</u> MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   | 22c. DATE SIGNED <u>2/22/68</u>   |  |   |  |   |   |                             |  |
| 22d. PHYSICIAN'S NAME (Type) <u>L.P. Bergen</u>   |  |  |   | 22e. ADDRESS <u>8100 Hartford Rd</u>  |  |   |  |   |   |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE <u>2/24/1968</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>                           |  |   |   |                             |  |
| 24. FUNERAL DIRECTOR <u>Charles F. Evans &amp; Son</u>  |  |  |   | ADDRESS <u>8802 Hartford Rd</u>   |  | 25a. REC'D BY REGISTRAR <u>DATE FEB 26 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |   |                             |  |

17636

ORIGINAL OF THE

02387



ORIGINAL OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |   |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First Middle Last  |   |  | 2a. DATE OF DEATH  |  |  | 2b. HOUR                                     |
| PAUL WILLIAM WAGNER   |  |  |  |   |  | Month Day Year<br>FEB 25 68  |  |  | 4:46 AM                                      |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  |
| MALE  |  | WHITE  |  | MAY 6, 1896   |  | 71 YRS.  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |  |  |
| CARROLL CO. MD.   |  | U.S.A.   |  |   |  | BALTIMORE Co. Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| OWINGS MILLS  |  |  | 100 ENCHANTED HILLS ROAD   |   |  | RAPID TRANSIT EMPLOYEE   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| MARYLAND  |  |  | BALTIMORE  |   |  | OWINGS MILLS   |  | 13e. STREET AND NUMBER   |  |
|   |  |  |  |   |  |  |  | 100 ENCHANTED HILLS ROAD   |  |
| 14. FATHER'S NAME First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |   |  |  |  |  |  |
| PETER S. WAGNER   |  |  | ELIZABETH ANGELL   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT  |  | Address  |  |  |
|   |  |  | 213-10-1553  |   | MRS. MATILDA C. WAGNER   |  | SAME ADDRESS   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (a) 4109 Coronary Thrombosis - acute  |  |  |  |   |  |  |  |  | 3 hours                                      |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis - generalized   |  |  |  |   |  |  |  |  | Years  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema - chronic   |  |  |  |   |  |  |  |  | Years  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |  |  |  |  |
| 4201  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
|   |  |  |  |   |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
|   |  |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
|   |  |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from December, 1967, to February 25, 1968, that (I) (we) last saw the deceased alive on February 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE Clarence E. McWilliams   |  |  |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED 2-25-68   |  |
| 22d. PHYSICIAN'S NAME (Type) CLARENCE E. MC-WILLIAMS  |  |  |  |   |  | 22e. ADDRESS 11904 Renterstown Rd. Renterstown Md. 21136   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |
| BURIAL  |  | 2/27/68  |  | ZION METH. CEM.   |  | WESTMINSTER RD. MD.  |  |  |  |
| 24. FUNERAL DIRECTOR J.S. Murrill, Westminister Md.   |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |
|   |  |  |  |   |  | DATE FEB 28 1968   |  |  |  |

97320

STATE OF TEXAS  
COUNTY OF DALLAS

97320

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, at Dallas, Texas, this 1st day of January, 1901.

\_\_\_\_\_  
County Clerk

\_\_\_\_\_  
Notary Public



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90  
30  
4

2

2

MEDICAL CERTIFICATION

| 02385   |  |   |  | 02373  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last<br><b>Margaret May Walker</b>  |  |   |  | 2a. DATE OF DEATH Month Day Year<br><b>February 16, 1968</b>   |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH<br><b>October 29, 1878</b>  |  | 6. AGE (In years lost birthday) YRS.<br><b>89</b>  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto. 12</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Armacost N. H.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>429 Kenneth Square</b>   |  | 14. FATHER'S NAME First Middle Last<br><b>John Roberts</b>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Rosella Whitney</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220-46-6696</b>  |  | 17. INFORMANT<br><b>Miss Edith V. Walker</b>   |  | Address<br><b>(same)</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recurrent cerebral thrombosis</b><br><b>4120</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arterial hypertension</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 1/2 yrs</b><br><b>18+ yrs</b><br><b>18+ yrs.</b> |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>443X</b>   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                          |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Apr 3, 1950</b> , to <b>Feb 16, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Feb 13, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Frederick J. Vollmer</b>   |  |   |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><b>Feb 17, 1968</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. Frederick J. Vollmer</b>   |  |   |  | 22e. ADDRESS<br><b>6100 York Road</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/19/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b>                        |  |
| 24. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co. 4905 York Road Baltimore Md. 21212</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>Feb 19 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>                                  |  |





AT&T

03388

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

02387

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02375

|  |  |  |  |   |  |   |  |  |  |                                      |  |   |  |
|--|--|--|--|---|--|---|--|--|--|--------------------------------------|--|---|--|
| 1. DECEASED-NAME<br>(Type or print)<br><b>Dora</b>   |  | First<br><b>Dora</b>   |  | Middle<br><b>Ward</b>   |  | Last<br><b>Ward</b>   |  | 2a. DATE OF DEATH<br><b>2</b> Month <b>2</b> Day <b>68</b> Year                    |  |                                      |  | 2b. HOUR<br><b>2:06 P M</b>                     |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Negro</b>  |  | 5. DATE OF BIRTH<br><b>12-17-1901</b>   |  |   |  | 6. AGE (In years<br>lost birthday)<br><b>66</b> YRS.                               |  | IF UNDER 1 YEAR<br>MONTHS DAYS       |  | IF UNDER 24 HRS.<br>HOURS MIN.                  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><b>Norfolk, Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Towson BALTO.</b> Md.  |  |  |  |                                      |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><b>Greater Balto Med Center</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br><b>None</b> |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  | 13e. STREET AND NUMBER<br><b>3505 Plateau Avenue</b>                               |  |                                      |  |   |  |
| 14. FATHER'S NAME<br><b>CALOB KEYS</b>   |  | First<br><b>CALOB</b>  |  | Middle<br><b>KEYS</b>   |  | Last<br><b>KEYS</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>MARY KEYS</b>                                       |  | First<br><b>MARY</b>                 |  | Middle<br><b>KEYS</b>                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br><b>No.</b>  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Rev. H. Ward</b>  |  |   |  | Address<br><b>3505 Plateau Avenue</b>  |  |                                      |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>lost. (b) <b>Renal failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic cardiovascular disease &amp; diabetes mellitus</b> |  |  |  |   |  |   |  |  |  |                                      |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>  |  |  |  |   |  |   |  |  |  |                                      |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <b>Yes</b> |  |                                      |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |                                      |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |                                      |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 10</b> , 19 <b>68</b> , to <b>Feb 2</b> , 19 <b>68</b> , that (I) (we) last<br>saw the deceased alive on <b>Feb 2</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |  |  |                                      |  |   |  |
| 22b. SIGNATURE<br><b>John E. Adams</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING<br>PHYS. <input type="checkbox"/> MED.<br>DIRECTOR <input type="checkbox"/> STAFF<br>PHYS. <input checked="" type="checkbox"/>                    |  | 22c. DATE SIGNED<br><b>2/3/68</b>   |  |  |  |                                      |  |   |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br><b>John E. Adams, M.D.</b>  |  | 22e. ADDRESS<br><b>6701 N. Charles St. Towson, Md.</b>   |  |   |  |   |  |  |  |                                      |  |   |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-7-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greater Sweet Beulah</b>   |  |   |  | 23d. LOCATION (City or Town)<br><b>Sulfolk</b>                                     |  | (County)<br><b>Virginia</b>          |  | (State)   |  |
| 24. FUNERAL DIRECTOR<br><b>MORTON &amp; DYETT F.H.</b>   |  | ADDRESS<br><b>1701 Laurens St.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>FEB 7 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>   |  |  |  |                                      |  |   |  |

02331

02331

12-17-1961

London

London, W. S. S.

Home

3800 Johnson Avenue

Bellevue

Bellevue

Bellevue

Home

3800 Johnson Avenue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue

Bellevue



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

Items 7a, 7b, 13, 71, 815  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
02384  
MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

03590

|   |  |                |   |                             |  |  |  |  |                                     |  |  |  |  |
|---|--|----------------|---|-----------------------------|--|--|--|--|-------------------------------------|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)<br>Everett Andrew Warren  |  |                | 2a. DATE OF DEATH<br>Month 2 Day 25 Year 68   |                             |  | 2b. HOUR<br>5:35 PM  |  |  |                                     |  |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Cau |   | 5. DATE OF BIRTH<br>8/18/67 |  | 6. AGE (In years last birthday)<br>6 months  |  | IF UNDER 1 YEAR<br>MONTHS 6 DAYS 7   |                                     | IF UNDER 24 HRS.<br>HOURS MIN.                   |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  |                | 7b. CITIZEN OF WHAT COUNTRY?  |                             |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Baltimore Md. |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore  |  |                | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Greater Baltimore Med. Center |                             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |                | 13b. COUNTY<br>Baltimore  |                             |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                                     | 13e. STREET AND NUMBER<br>1282 Woodbourne Avenue |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Everett Paul Warren  |  |                | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Patricia Margaret Mosiej  |                             |  |  |  |  |                                     |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |                | 16b. SOCIAL SECURITY NO.  |                             |  | 17. INFORMANT Address  |  |  |                                     |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Congenital hydrocephalus<br>742X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                |   |                             |  |  |  |  |                                     |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>752X  |  |                |   |                             |  |  |  |  |                                     |  |  |  |  |
| 19a. DATE OF OPERATION  |  |                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES          |                                     |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |                | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |                             |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                                     |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  |                | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |                             |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |                                     |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/20, 1968, to 2/25, 1968, that (I) (we) last saw the deceased alive on 2/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |                |   |                             |  |  |  |  |                                     |  |  |  |  |
| 22b. SIGNATURE<br>R. Breitenecker   |  |                |   |                             |  | 22c. DATE SIGNED<br>2/25/68  |  |  |                                     |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>R. Breitenecker, M.D.   |  |                |   |                             |  | 22e. ADDRESS<br>6701 N. Charles Street   |  |  |                                     |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>cremation  |  |                | 23b. DATE<br>2/27/68  |                             | 23c. NAME OF CEMETERY OR CREMATORY<br>GBMC |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Towson, MD, 21204                   |                                     |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>R. Breitenecker   |  |                |   |                             |  | ADDRESS<br>GBMC  |  | 25a. REC'D BY REGISTRAR<br>DATE MAR 12 1968  |                                     | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge      |  |  |  |

02384

U.S. BUREAU OF DEATH

02384

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Drugs Taken

Alcohol Consumed

Smoking Habits

Family History

Other Information

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |  |   |   |   |  |                                |   |                               |                                    |  |
|---|--|---|--|--|---|---|---|--|--------------------------------|---|-------------------------------|------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |   |   |   |  |                                |   |                               |                                    |  |
| CERTIFICATE OF DEATH  |  |   |  |  |   |   |   |  |                                |   |                               |                                    |  |
| 1. DECEASED-NAME (Type or print)<br>First Middle Last<br><b>MARGUERITE E. WATERS</b>  |  |   |  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><b>February 20th., 1968</b>  |   |  | 2b. HOUR<br><b>2:15 P.M.</b>   |   |                               |                                    |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br><b>Dec. 21st., 1881</b>  |   |   | 6. AGE (In years last birthday)<br><b>86</b> YRS.                     |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN |                                    |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |   |  |                                |   |                               |                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville,</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>College Manor Nursing Home</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Saleslady</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired-Sale</b> |                                |   |                               |                                    |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>New York</b>  |  | 13b. COUNTY<br><b>✓</b>   |  | 13c. CITY OR TOWN<br><b>New York</b>   |   | 13d. INSIDE CITY LIMITS?<br><b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><b>132 E. 54th., Street</b>    |                                |   |                               |                                    |  |
| 14. FATHER'S NAME First Middle Last<br><b>Robert Eugene Waters</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Henrietta Tubman</b>   |   |   |   |  |                                |   |                               |                                    |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>088-09-6319</b>  |  | 17. INFORMANT Address<br><b>Atty: Mr. John T. Kenney, Mercantile Safe &amp; Trust</b>  |   |   |   |  |                                |   |                               |                                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary heart failure</b><br><b>4409</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>pneumonia + arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Generalized arteriosclerosis</b><br><b>4500</b> |  |   |  |  |   |   |   |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>2 wks</b><br><b>Grav</b>                                     |                               |                                    |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |  |  |   |   |   |  |                                |   |                               |                                    |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br><b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>          |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                                |   |                               |                                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |   |   |   |  |                                |   |                               |                                    |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                      |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |  |                                |   |                               |                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2-5, 1958</b> , to <b>2-20, 1968</b> , that (I) (we) last saw the deceased alive on <b>2-13, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |  |   |   |   |  |                                |   |                               |                                    |  |
| 22b. SIGNATURE<br><b>William F. Fritz</b> M.D. DEGREE   |  |   |  |  |   |   |   |  |                                | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                               | 22c. DATE SIGNED<br><b>2/20/68</b> |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Dr. William F. Fritz</b>   |  |   |  | 22e. ADDRESS<br><b>2 W. University Pkwy.</b>   |   |   |   |  |                                |   |                               |                                    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2/23/68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Md.</b> |  |                                |   |                               |                                    |  |
| 24. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b>   |  |   |  | ADDRESS<br><b>4905 York Rd. Balto. 12, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>Fcb 21 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>         |                                |   |                               |                                    |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |  |  |  |   |  |                            |
|---|--|--|---|--|--|--|--|--|---|--|----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |  |  |  |   |  |                            |
| CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |   |  |                            |
| 1. DECEASED-NAME (Type or print) <b>William Nicklin Watmough, Jr.</b>   |  |  |   |  |  | 2a. DATE OF DEATH <b>February 13, 1968</b>   |  |  | 2b. HOUR <b>8:30</b> A.M.                       |  |                            |
| 3. SEX <b>M</b>   |  | 4. RACE <b>W</b>   |   | 5. DATE OF BIRTH <b>4/6/1901</b>   |  |  | 6. AGE (In years lost birthday) <b>66</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS                     |  | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Baltimore</b> Md.  |  |  |   |  |                            |
| 10. CITY OR TOWN OF DEATH <b>Ruxton</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>7901 Bellona Ave.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Executive Davidson Chemical Co.</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY               |  |                            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>  |  |  | 13b. COUNTY <b>Balto.</b>   |  | 13c. CITY OR TOWN <b>Ruxton</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>7901 Bellona Ave.</b> |  |                            |
| 14. FATHER'S NAME First Middle Last <b>William Nicklin Watmough</b>   |  |  |   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Davidson</b>  |  |  |   |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO. <b>213-01-6390</b>   |  | 17. INFORMANT <b>Harrison M. Robertson, Jr. Bank Bldg.</b> Address <b>1445 Md. Nat'l</b> |  |  |  |   |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the pancreas with metastasis to the liver</b><br><b>1579</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>About 4 months</b> |  |  |   |  |  |  |  |  |   |  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>157X</b>  |  |  |   |  |  |  |  |  |   |  |                            |
| 19a. DATE OF OPERATION <b>11/10/67.</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Liver biopsy, Gastrojejunostomy, Exploratory laparotomy.</b> |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |                            |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |   |  |                            |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                     |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |   |  |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/11/32</b> , 19____, to <b>2/13/68</b> , 19____, that (I) (we) lost the deceased alive on <b>2/9/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |  |  |  |  |  |   |  |                            |
| 22b. SIGNATURE <b>Edwin B. Jarrett M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |  |  | 22c. DATE SIGNED <b>2/14/68.</b>   |  |  |   |  |                            |
| 22d. PHYSICIAN'S NAME (Type) <b>Dr. Edwin B. Jarrett</b>  |  |  |   |  |  | 22e. ADDRESS <b>11 E. Chase St.</b>  |  |  |   |  |                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>2/14/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>  |  |  |   |  |                            |
| 24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR <b>DATE FEB 15 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                      |   |  |                            |

MEDICAL CERTIFICATION

02330

02330

UNITED STATES OF AMERICA

IN SENATE, January 11, 1950

REPORT OF THE

COMMISSION ON THE ORGANIZATION OF THE EXECUTIVE BRANCH

FOR THE YEAR 1949

BY THE COMMISSIONERS

OF THE COMMISSION ON THE ORGANIZATION OF THE EXECUTIVE BRANCH

FOR THE YEAR 1949

UNITED STATES GOVERNMENT PRINTING OFFICE

WASHINGTON, D. C. 20540

1950

1950

1950

1950

1950

1950

1950

1950

1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
|--|--|--|--|---|--------------------------|---|---|--|-------------------------------------|--|--------------------|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| CERTIFICATE OF DEATH   |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  |   | Middle                   |   | Last  |  | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR<br>11a. M |                                |  |
| Alice  |  |  | B.   |   | Watson                   |   |   |  | Feb 22 1968                         |  | 11a. M             |                                |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |                          |   |   | 6. AGE (In years last birthday)                                      |                                     | IF UNDER 1 YEAR<br>MONTHS DAYS               |                    | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| Female   |  | White  |  | 11-8-1908   |                          |   |   | 59 YRS.  |                                     |  |                    |                                |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |   |                          | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |                                     |  |                    |                                |  |
| Maryland   |  |  | U.S.A.   |   |                          |   |   | Baltimore Md.  |                                     |  |                    |                                |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                          |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)         |  |                                     | 12b. KIND OF BUSINESS OR INDUSTRY            |                    |                                |  |
| Lansdowne  |  |  | 3212 Rosalie Rd. 21227   |   |                          |   |   |  |                                     |  |                    |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN        |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER              |  |                    |                                |  |
| Maryland   |  |  | Balto.   |   | Lansdowne                |   |   |  | 3212 Rosalie Road                   |  |                    |                                |  |
| 14. FATHER'S NAME  |  |  | First  |   | Middle                   |   | Last  |  | 15. MOTHER'S MAIDEN NAME            |  |                    |                                |  |
| John Bowen   |  |  |  |   |                          |   |   |  | Edythe Muhles                       |  |                    |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT            |   | Address   |  | 21227                               |  |                    |                                |  |
|  |  |  | 213-03-3588  |   | Mr. James A. Watson, Jr. |   | 3212 Rosalie Rd.  |  |                                     |  |                    |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |  |   |                          |   |   |  |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                    |                                |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with congestive heart failure -</u>  |  |  |  |   |                          |   |   |  |                                     | 6 years -                                    |                    |                                |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>unknown -</u>   |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4200 DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Bronchitis -</u>   |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |                          | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                     |  |                    |                                |  |
|  |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. - Month Day Year<br>P.M. 19                 |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |                          |   |   |  |                                     |  |                    |                                |  |
|  |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |                          | Street or R.F.D. No.  |   | City or Town   |                                     | County                                       |                    | State                          |  |
|  |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/14, 1967</u> to <u>2/22, 1968</u> , that (I) (we) last saw the deceased alive on <u>2/9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| 22b. SIGNATURE <u>Cesar J. Pellerano</u> MED. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED <u>2-23-68</u>   |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Cesar J. Pellerano</u> 22e. ADDRESS <u>1311 Glenmont Rd / 2436 Washington Blvd.</u>  |  |  |  |   |                          |   |   |  |                                     |  |                    |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |                          | 23d. LOCATION (City or Town)  |   | (County)   |                                     | (State)                                      |                    |                                |  |
| Burial   |  | 2-26-1968  |  | Loudon Park Cemetery  |                          | Baltimore, Maryland   |   |  |                                     |  |                    |                                |  |
| 24. FUNERAL DIRECTOR   |  |  |  |   |                          | ADDRESS   |   | 25a. REC'D BY REGISTRAR  |                                     | 25b. REGISTRAR'S SIGNATURE                   |                    |                                |  |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229   |  |  |  |   |                          |   |   | FEB 29 1968  |                                     | <u>Charles Judge</u>                         |                    |                                |  |

0260

87620

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 02392   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 02379  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | First Middle Last  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| ALEX  |  |  |  |  |  |  |  |  |  | WEINER   |  |  |  |  |  |  |  |  |  | FEBRUARY   |  |  |  |  |  |  |  |  |  | 12, 1968   |  |  |  |  |  |  |  |  |  | 6:35 AM                     |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX  |  |  |  |  |  |  |  |  |  | 4. RACE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday)  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| MALE  |  |  |  |  |  |  |  |  |  | WHITE  |  |  |  |  |  |  |  |  |  | MAY 31, 1924   |  |  |  |  |  |  |  |  |  | 43 YRS.  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| MARYLAND  |  |  |  |  |  |  |  |  |  | U.S.A.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| TOWSON  |  |  |  |  |  |  |  |  |  | ST. JOSEPH HOSPITAL  |  |  |  |  |  |  |  |  |  | PHARMACIST   |  |  |  |  |  |  |  |  |  | LYKOS PHARMA   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  |  |  |  |  |  |  |  | 13b. COUNTY  |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER      |  |  |  |  |  |  |  |  |  | 13f. ZIP CODE               |  |  |  |  |  |  |  |  |  |
| MARYLAND  |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  |  |  |  |  |  | BALTIMORE  |  |  |  |  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |  |  |  |  |  |  |  |  | 3116 LIGHTFOOT DRIVE        |  |  |  |  |  |  |  |  |  | #21208                      |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| ABRAHAM   |  |  |  |  |  |  |  |  |  | WEINER   |  |  |  |  |  |  |  |  |  | SARAH  |  |  |  |  |  |  |  |  |  | BULMASH  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  | 17. INFORMANT  |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| YES   |  |  |  |  |  |  |  |  |  | U.W. 11  |  |  |  |  |  |  |  |  |  | MRS. BARBARA WEINER  |  |  |  |  |  |  |  |  |  | 3116 LIGHTFOOT DR. #21209  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 442X  |  |  |  |  |  |  |  |  |  | 453X   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  | IMMEDIATE CAUSE (a)  |  |  |  |  |  |  |  |  |  | Ruptured anterior communicating artery   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |  |  | (b)  |  |  |  |  |  |  |  |  |  | intercranial hemorrhage  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | (c)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 30, 1968, to FEBRUARY 12, 1968, that (I) (we) last saw the deceased alive on FEBRUARY 12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Jaime Ambrad, M.D.  |  |  |  |  |  |  |  |  |  | 2-12-68  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| Jaime Ambrad, M.D.  |  |  |  |  |  |  |  |  |  | 7620 York Road, Baltimore, Md. 21204   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  | 23b. DATE  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| BURIAL  |  |  |  |  |  |  |  |  |  | 2-13-68  |  |  |  |  |  |  |  |  |  | BETH YEHUDA ANSHE KURLAND  |  |  |  |  |  |  |  |  |  | BALTIMORE, MARYLAND  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| SOL LEVINSON & BROS.,   |  |  |  |  |  |  |  |  |  | 6010 REISTERSTOWN ROAD   |  |  |  |  |  |  |  |  |  | DATE FEB 14 1968   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |

05380

05333

1955

15

1955

15

1955

1955

1955

MARYLAND STATE DEPARTMENT OF HEALTH

02393 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 2 Film G398 3/15/68 kk

CERTIFICATE OF DEATH

02350

|   |                               |   |                                    |
|---|-------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE</b><br>c. LENGTH OF STAY IN 1b  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PIKESVILLE Baltimore</b> |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Melford Manor Nursing Home</b>  |                               | d. STREET ADDRESS <b>5519 Oakland Road</b>  |                                    |
| 3. NAME OF DECEASED (Type or print) <b>Fernie Wellen</b>  |                               | 4. DATE OF DEATH <b>12 28 19 68</b>   |                                    |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>12-22-1877</b> |
| 9. AGE (In years last birthday) <b>90</b> yrs.  |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES LADY</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>  |                                    |
| 11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                                    |
| 13. FATHER'S NAME <b>Isaac Wellen</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Rosa Senker</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                               | 16. SOCIAL SECURITY NO. <b>212-09-9421</b>  |                                    |
| 17. INFORMANT <b>MRS. ESTHER R. KOPPELMANN</b>  |                               | Address <b>5819 OAKLAND RD. #27</b>   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4129</b> IMMEDIATE CAUSE (a) <b>Arteriosclerosis C.V.D.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH <b>40 yrs</b> |                               |   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4221 Recurrent psychosis, depressive type</b>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that (I) (this hospital) attended the deceased from <b>19 60</b> to <b>20 4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12 28 19 68</b> , and that death occurred at <b>8 AM</b> , from causes and on the date stated above.   |                               |   |                                    |
| 22a. SIGNATURE <b>Joseph B. Gross</b>   |                               | 22b. DATE SIGNED  |                                    |
| 22c. PHYSICIAN'S NAME (Type) <b>Joseph B. Gross</b>   |                               | 22d. ADDRESS <b>6911 Park Heights C</b>   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                               | 23b. DATE THEREOF <b>3-1-68</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>   |                               | 23d. LOCATION (City or town) (County) (State) <b>BALTIMORE, MARYLAND</b>  |                                    |
| 24. FUNERAL DIRECTOR <b>Sol Levinson &amp; Bros.</b>  |                               | ADDRESS <b>6010 REISTERSTOWN ROAD</b>   |                                    |
| 25a. REC'D BY REGISTRAR <b>1968</b>   |                               | 25b. REGISTRAR'S SIGNATURE <b>John A. [Signature]</b>   |                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08307

02300

STATEMENT OF DEATH

MARYLAND

BALTIMORE

PITTSVILLE

PITTSVILLE

U.S.A.

BALTIMORE, MARYLAND

RETIRED

SALESMAN

210 OAKLAND RD. 752  
ESTHER S. KOPPELMANN

NEEDS FRIENDSHIP

3-1-68

BALTIMORE, MARYLAND

4010 REGISTERED MAR 1 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

Item #13 Film #G3972/14/68 ph  
02394

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02381

|  |  |  |   |  |  |   |  |  |   |  |  |   |  |                               |  |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|-------------------------------|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Blanche</b>   |  |  | First Middle Last <b>Wessel</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>2</b> Day <b>3</b> Year <b>68</b>   |  |  | 2b. HOUR<br><b>4:10</b> A M   |  |  |   |  |                               |  |  |  |
| 3. SEX<br><b>Female</b>  |  |  | 4. RACE<br><b>White</b>   |  |  | 5. DATE OF BIRTH<br><b>8/10/95</b>  |  |  | 6. AGE (In years last birthday)<br><b>42</b> YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.  |  |  |   |  |                               |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rosewood State Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>none</b>  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |  |  |   |  |                               |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>2222 Laurel St.</b><br><b>SPRING GROVE HOSP.</b> |  |                               |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br><b>William J. Wessel</b>   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Euboin At Kins</b>                                      |  |  |   |  |  |   |  |  |   |  |                               |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>218-54-0505</b>  |  |  | 17. INFORMANT<br>Address<br><b>Rosewood Records, Owings Mills, Md.</b>  |  |  |   |  |  |   |  |                               |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>486x</b> IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |  |   |  |  |   |  |  |   |  |                               | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>490x Dysphagia</b>  |  |  |   |  |  |   |  |  |   |  |  |   |  |                               |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |   |  |                               |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |                               |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |   |  |  |   |  |                               |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 2, 1968</b> , to <b>Feb. 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb. 3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |  |  |   |  |                               |  |  |  |
| 22b. SIGNATURE<br><b>Remzi Demir, M.D.</b>   |  |  | DEGREE<br><b>REMZI M. DEMIR, M.D.</b>   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>Feb. 3, 68</b>   |  |  |   |  |                               |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>REMZI M. DEMIR, M.D.</b>  |  |  | 22e. ADDRESS<br><b>Rosewood Box 200 Owings Mills, Md. 21117</b>   |  |  |   |  |  |   |  |  |   |  |                               |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>2/6/68</b>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>                      |  |  |   |  |                               |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Robert C. Altenburg Funeral Home, Inc.</b>  |  |  | ADDRESS<br><b>6009 Harford Rd. - Balto., Md. 21214</b>  |  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 7 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |   |  |                               |  |  |  |

123281

123281

123281

(Faint, illegible text, possibly bleed-through from the reverse side of the page)

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-403. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02395

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02382

|  |  |  |   |  |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |  |  | First Middle Last   |  |  | 2a. DATE KNOWN OF DEATH  |  |  | 2b. HOUR   |  |  |
| ROBERT   |  |  | H.  |  |  | WHITE  |  |  | Month Day Year   |  |  |
| 3. SEX   |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH   |  |  | 6. AGE (In years last birthday)  |  |  |
| Male   |  |  | White   |  |  | Nov. 16, 1923  |  |  | 44 YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH   |  |  |
| Virginia   |  |  | U. S. A.  |  |  |  |  |  | BALTIMORE Md.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)                    |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Edgemere   |  |  | 2805 Wells Avenue   |  |  | Clerk - Post Office  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| Md.  |  |  | Baltimore   |  |  | Edgemere   |  |  | 2805 Wells Avenue  |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  |
| Robert   |  |  | White   |  |  | Margaret   |  |  | Langford   |  |  |
| 17. INFORMANT (Wife)   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                       |  |  | 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |
| Mrs. Thelma White, 2805 Wells Rd. Edgemere,  |  |  | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> |  |  | 4129   |  |  | 4221   |  |  |
|  |  |  | (b) <u></u>   |  |  |  |  |  |  |  |  |
|  |  |  | (c) <u></u>   |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY Month, Day, Year  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |
|  |  |  | 19  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |  |  | 21f. LOCATION Street or R.F.D. No.   |  |  | City or Town County State  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  | 22b. DATE SIGNED  |  |  | 22c. NAME OF CEMETERY OR CREMATORY   |  |  | 22d. LOCATION (City or Town) (County) (State)  |  |  |
| Charles S. Springate, M.D.   |  |  | February 16, 1968   |  |  | Balto. National Cem.   |  |  | Baltimore, Md.   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Burial   |  |  | 2/19/68   |  |  | Balto. National Cem.   |  |  | Baltimore, Md.   |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. REC'D BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| John J. Duda, 7922 Wise Ave. Dundalk, Md.  |  |  | DATE 2 19 1968  |  |  |  |  |  |  |  |  |

05333

05333

RECEIVED

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |   |  |                                  |  |  |  |   |   |   |
|---|--|---|---|--|----------------------------------|--|--|--|---|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |  |                                  |  |  |  |   |   |   |
| CERTIFICATE OF DEATH  |  |   |   |  |                                  |  |  |  |   |   |   |
| 1. DECEASED-NAME (Type or print) <b>CHARLES F. WILLIAMS</b>   |  |   |   |  |                                  | 2a. DATE OF DEATH <b>Feb</b> Month <b>17</b> Day <b>1968</b> Year                                      |  |  | 2b. HOUR <b>M</b>                                 |   |   |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>  |   | 5. DATE OF BIRTH <b>July 7, 1889</b>   |                                  |  | 6. AGE (In years last birthday) <b>78</b> YRS.   |  | IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>       |   | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> |
| 7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |  |  |   |   |   |
| 10. CITY OR TOWN OF DEATH <b>DUNDALK</b>  |  |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1601 INVERNESS ROAD</b> |  |                                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Railroad</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b></b>         |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |  |   | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN <b>Dundalk</b> |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>1601 Inverness Road</b> |   |   |
| 14. FATHER'S NAME First <b>Edward</b> Middle <b>M.</b> Last <b>Williams</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>F.</b> Last <b>Martin</b>   |                                  |  |  |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>214-09-8984</b>   |   | 17. INFORMANT (Daughter) <b>Mrs. Mary Thacker, 1601 Inverness Road,</b>  |                                  |  |  | Address <b>Dundalk, Md.</b>  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of the lungs</b><br><b>1621</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b></b> DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |   |   |  |                                  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YR.</b> |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>163x</b>  |  |   |   |  |                                  |  |  |  |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |                                  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b></b> Day <b></b> Year <b></b> P.M. <b></b> |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                  |  |  |  |   |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                |   | 21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>   |                                  |  |  |  |   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1968</b> to <b>Feb 17, 1968</b> , that (I) (we) lost the deceased alive on <b>Feb 14, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |   |   |  |                                  |  |  |  |   |   |   |
| 22b. SIGNATURE <b>Stephen C. Mackowiak</b> DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |   |   |  |                                  | 22c. DATE SIGNED <b>2-17-68</b>  |  |  |   |   |   |
| 22d. PHYSICIAN'S NAME (Type) <b>STEPHEN C. MACKOWIAK M.D.</b>   |  |   |   |  |                                  | 22e. ADDRESS <b>6714 HOLABIRD AVE. BALT MD. 21222</b>  |  |  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>2/20/68</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>  |                                  |  | 23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>                         |  |   |   |   |
| 24. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  |   |   |  |                                  | 25a. REC'D BY REGISTRAR <b>DATE Feb 19 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>                   |   |   |   |

03230

03230

CERTIFICATE OF DEATH

DATE OF DEATH

TIME

PLACE

AGE

SEX

19

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919

1919



2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 02397   |  | MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |   |  | 02384   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First  |  | Middle  |  | Last  |  | 2a. DATE OF DEATH<br>Month Day Year   |  | 2b. HOUR<br>a. M.  |  |
| MC KINNIS   |  |  |  | WILLIAMS  |  |   |  | FEBRUARY 24 1968  |  | 2:30 a. M.   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>NEGRO   |  | 5. DATE OF BIRTH<br>SEPTEMBER 26, 1927  |  | 6. AGE (In years last birthday)<br>40 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>MASSACHUSETTS  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>BALTIMORE   |  |   |  | Md.  |  |
| 10. CITY OR TOWN OF DEATH<br>FORT HOWARD  |  | 11. NAME OF HOSPITAL OR INSTITUTION (Give street address)<br>VETERANS ADMINISTRATION                               |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>SERVICE MAN  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RADIO & TV   |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE   |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>1716 WARWICK AVENUE   |  |  |  |
| 14. FATHER'S NAME<br>ERNEST WILLIAMS  |  | First Middle Last  |  | 15. MOTHER'S MAIDEN NAME<br>Edna Mae Lewis  |  | First Middle Last   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) YES  |  | 16b. SOCIAL SECURITY NO.<br>WW-11 421 20 75 16   |  | 17. INFORMANT<br>CLIN. REC., VET. ADM. HOSP. FT. HOWARD, MD   |  | Address   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>ELECTROLYTE EMBOLANCE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>DIABETES MELLITUS</u>  |  |  |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 MINUTES<br>3 DAYS<br>5 YEARS |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>PANCREATITIS</u>   |  |  |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>YES   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                       |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |   |  |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>Feb. 21</u> , 19 <u>68</u> , to <u>Feb. 24</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 24</u> , 19 <u>68</u> , and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Ralph M. Howard MD</u> DEGREE  |  |  |  |   |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>2/24/68  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>RALPH M. HOWARD, M.D.   |  |  |  |   |  |   |  | 22e. ADDRESS<br>VET. ADM. HOSP., FT. HOWARD, MD.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  | 23b. DATE<br>Feb 29, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore National Cemetery   |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Nutter Funeral Home   |  | 3035 W. North Ave.<br>Baltimore, Maryland  |  | 25a. REC'D BY REGISTRAR<br>DATE FEB 27 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |  |  |  |

12320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M

02393

MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02385

|   |  |  |   |   |  |  |  |
|---|--|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Sophia E. Williamson</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>12</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>4</b> M   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br><b>Apr. 28, 1883</b>  |  | 6. AGE (In years last birthday)<br><b>84</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Germany</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Baltimore</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Shady Nook Nur.Home</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>House-wife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Woodlawn</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>5503 W. North Ave.,</b>  |  |  |   |   |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>Christian Kraft</b>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Dorothea Zies</b>    |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, ar (unknown) (If yes give war or dates of service)<br><b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>216-09-3690</b>                        |   | 17. INFORMANT Address<br><b>Mrs. George V. Wise 1201 Cedar Circle Ct</b> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b><br><b>4129</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio sclerosis C.V.D.</b> |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 hr</b><br><b>3 hr</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221</b>   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/13</b> , 19 <b>62</b> , to <b>2/12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>1/30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |  |   |   |  |  |  |
| 22b. SIGNATURE <b>Cliff Ratliff, Jr.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |   |   |  | 22c. DATE SIGNED<br><b>2/13/68</b>   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR.</b>  |  |  |   | 22e. ADDRESS<br><b>4605 EAM-ROSON AVE</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>2-15-1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Md.</b>                        |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>G. Howard Strong 3207 W. North Ave.,</b>   |  |  |   | 25a. REC'D BY REGISTRAR<br><b>FEB 14 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE   |  |

12888

REVENUE OF 1941

12888

| 1941 |  | 1942 |  | 1943 |  | 1944 |  | 1945 |  | 1946 |  | 1947 |  | 1948 |  | 1949 |  | 1950 |  | 1951 |  | 1952 |  | 1953 |  | 1954 |  | 1955 |  | 1956 |  | 1957 |  | 1958 |  | 1959 |  | 1960 |  | 1961 |  | 1962 |  | 1963 |  | 1964 |  | 1965 |  | 1966 |  | 1967 |  | 1968 |  | 1969 |  | 1970 |  | 1971 |  | 1972 |  | 1973 |  | 1974 |  | 1975 |  | 1976 |  | 1977 |  | 1978 |  | 1979 |  | 1980 |  | 1981 |  | 1982 |  | 1983 |  | 1984 |  | 1985 |  | 1986 |  | 1987 |  | 1988 |  | 1989 |  | 1990 |  | 1991 |  | 1992 |  | 1993 |  | 1994 |  | 1995 |  | 1996 |  | 1997 |  | 1998 |  | 1999 |  | 2000 |  | 2001 |  | 2002 |  | 2003 |  | 2004 |  | 2005 |  | 2006 |  | 2007 |  | 2008 |  | 2009 |  | 2010 |  | 2011 |  | 2012 |  | 2013 |  | 2014 |  | 2015 |  | 2016 |  | 2017 |  | 2018 |  | 2019 |  | 2020 |  | 2021 |  | 2022 |  | 2023 |  | 2024 |  | 2025 |  | 2026 |  | 2027 |  | 2028 |  | 2029 |  | 2030 |  | 2031 |  | 2032 |  | 2033 |  | 2034 |  | 2035 |  | 2036 |  | 2037 |  | 2038 |  | 2039 |  | 2040 |  | 2041 |  | 2042 |  | 2043 |  | 2044 |  | 2045 |  | 2046 |  | 2047 |  | 2048 |  | 2049 |  | 2050 |  | 2051 |  | 2052 |  | 2053 |  | 2054 |  | 2055 |  | 2056 |  | 2057 |  | 2058 |  | 2059 |  | 2060 |  | 2061 |  | 2062 |  | 2063 |  | 2064 |  | 2065 |  | 2066 |  | 2067 |  | 2068 |  | 2069 |  | 2070 |  | 2071 |  | 2072 |  | 2073 |  | 2074 |  | 2075 |  | 2076 |  | 2077 |  | 2078 |  | 2079 |  | 2080 |  | 2081 |  | 2082 |  | 2083 |  | 2084 |  | 2085 |  | 2086 |  | 2087 |  | 2088 |  | 2089 |  | 2090 |  | 2091 |  | 2092 |  | 2093 |  | 2094 |  | 2095 |  | 2096 |  | 2097 |  | 2098 |  | 2099 |  | 2100 |  | 2101 |  | 2102 |  | 2103 |  | 2104 |  | 2105 |  | 2106 |  | 2107 |  | 2108 |  | 2109 |  | 2110 |  | 2111 |  | 2112 |  | 2113 |  | 2114 |  | 2115 |  | 2116 |  | 2117 |  | 2118 |  | 2119 |  | 2120 |  | 2121 |  | 2122 |  | 2123 |  | 2124 |  | 2125 |  | 2126 |  | 2127 |  | 2128 |  | 2129 |  | 2130 |  | 2131 |  | 2132 |  | 2133 |  | 2134 |  | 2135 |  | 2136 |  | 2137 |  | 2138 |  | 2139 |  | 2140 |  | 2141 |  | 2142 |  | 2143 |  | 2144 |  | 2145 |  | 2146 |  | 2147 |  | 2148 |  | 2149 |  | 2150 |  | 2151 |  | 2152 |  | 2153 |  | 2154 |  | 2155 |  | 2156 |  | 2157 |  | 2158 |  | 2159 |  | 2160 |  | 2161 |  | 2162 |  | 2163 |  | 2164 |  | 2165 |  | 2166 |  | 2167 |  | 2168 |  | 2169 |  | 2170 |  | 2171 |  | 2172 |  | 2173 |  | 2174 |  | 2175 |  | 2176 |  | 2177 |  | 2178 |  | 2179 |  | 2180 |  | 2181 |  | 2182 |  | 2183 |  | 2184 |  | 2185 |  | 2186 |  | 2187 |  | 2188 |  | 2189 |  | 2190 |  | 2191 |  | 2192 |  | 2193 |  | 2194 |  | 2195 |  | 2196 |  | 2197 |  | 2198 |  | 2199 |  | 2200 |  | 2201 |  | 2202 |  | 2203 |  | 2204 |  | 2205 |  | 2206 |  | 2207 |  | 2208 |  | 2209 |  | 2210 |  | 2211 |  | 2212 |  | 2213 |  | 2214 |  | 2215 |  | 2216 |  | 2217 |  | 2218 |  | 2219 |  | 2220 |  | 2221 |  | 2222 |  | 2223 |  | 2224 |  | 2225 |  | 2226 |  | 2227 |  | 2228 |  | 2229 |  | 2230 |  | 2231 |  | 2232 |  | 2233 |  | 2234 |  | 2235 |  | 2236 |  | 2237 |  | 2238 |  | 2239 |  | 2240 |  | 2241 |  | 2242 |  | 2243 |  | 2244 |  | 2245 |  | 2246 |  | 2247 |  | 2248 |  | 2249 |  | 2250 |  | 2251 |  | 2252 |  | 2253 |  | 2254 |  | 2255 |  | 2256 |  | 2257 |  | 2258 |  | 2259 |  | 2260 |  | 2261 |  | 2262 |  | 2263 |  | 2264 |  | 2265 |  | 2266 |  | 2267 |  | 2268 |  | 2269 |  | 2270 |  | 2271 |  | 2272 |  | 2273 |  | 2274 |  | 2275 |  | 2276 |  | 2277 |  | 2278 |  | 2279 |  | 2280 |  | 2281 |  | 2282 |  | 2283 |  | 2284 |  | 2285 |  | 2286 |  | 2287 |  | 2288 |  | 2289 |  | 2290 |  | 2291 |  | 2292 |  | 2293 |  | 2294 |  | 2295 |  | 2296 |  | 2297 |  | 2298 |  | 2299 |  | 2300 |  | 2301 |  | 2302 |  | 2303 |  | 2304 |  | 2305 |  | 2306 |  | 2307 |  | 2308 |  | 2309 |  | 2310 |  | 2311 |  | 2312 |  | 2313 |  | 2314 |  | 2315 |  | 2316 |  | 2317 |  | 2318 |  | 2319 |  | 2320 |  | 2321 |  | 2322 |  | 2323 |  | 2324 |  | 2325 |  | 2326 |  | 2327 |  | 2328 |  | 2329 |  | 2330 |  | 2331 |  | 2332 |  | 2333 |  | 2334 |  | 2335 |  | 2336 |  | 2337 |  | 2338 |  | 2339 |  | 2340 |  | 2341 |  | 2342 |  | 2343 |  | 2344 |  | 2345 |  | 2346 |  | 2347 |  | 2348 |  | 2349 |  | 2350 |  | 2351 |  | 2352 |  | 2353 |  | 2354 |  | 2355 |  | 2356 |  | 2357 |  | 2358 |  | 2359 |  | 2360 |  | 2361 |  | 2362 |  | 2363 |  | 2364 |  | 2365 |  | 2366 |  | 2367 |  | 2368 |  | 2369 |  | 2370 |  | 2371 |  | 2372 |  | 2373 |  | 2374 |  | 2375 |  | 2376 |  | 2377 |  | 2378 |  | 2379 |  | 2380 |  | 2381 |  | 2382 |  | 2383 |  | 2384 |  | 2385 |  | 2386 |  | 2387 |  | 2388 |  | 2389 |  | 2390 |  | 2391 |  | 2392 |  |
|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|
|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|------|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|   |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|-----------------------------|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|--|--|
| 02399   |  |  |  |  |  |  |  |   |  |  |  | MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |                             |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |  |  |  |  |  |  |  |  |  |  |  | 02386 |  |  |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>Joseph Frank Wirth  |  |  |  |  |  |  |  |   |  |  |  | 2a. DATE OF DEATH Month Day Year<br>Feb. 8, 1968  |  |  |  |  |  |  |  |                             |  |  |  | 2b. HOUR<br>7:15 a.m.   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male  |  |  |  | 4. RACE<br>White   |  |  |  | 5. DATE OF BIRTH<br>May 21, 1908  |  |  |  | 6. AGE (In years last birthday)<br>59 YRS.  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Hungary  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH<br>Baltimore Md.   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Catonsville  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Spring Grove State Hospital                            |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Printer  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>B&O R R  |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Baltimore   |  |  |  | 13c. CITY OR TOWN<br>Baltimore  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  | 13e. STREET AND NUMBER<br>3618 Mary Avenue |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>John Wirth   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Helen Kanary <del>Xxxxx</del>  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT<br>Records: Spring Grove State Hospital   |  |  |  | Address   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac failure</u><br>401X<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Hypertensive disease</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>443X  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 12, 1937, to Feb. 8, 1967, that (I) (we) last saw the deceased alive on Feb. 8, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>A.B. Hooton   |  |  |  | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br>Feb. 8, 1968  |  |  |  |   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>A.B. Hooton, M.D.   |  |  |  | 22e. ADDRESS<br>Spring Grove State Hospital  |  |  |  |   |  |  |  |   |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  | 23b. DATE<br>2/10/68   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Cedar Hill Cemetery   |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Md.                                 |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Schimunek Funeral Home, Inc.<br>3331 Brehms Lane  |  |  |  | ADDRESS  |  |  |  | 25a. REC'D BY REGISTRAR<br>FEB 13 1968  |  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |                             |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |  |



48384

DEPARTMENT OF PLANT

05384

PLANT

PLANT

PLANT

PLANT

PLANT

PLANT

PLANT



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                              |  |  |                                       |   |                                 |  |  |
|--|--|------------------------------|--|--|---------------------------------------|---|---------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                              |  |  |                                       |   |                                 |  |  |
| CERTIFICATE OF DEATH   |  |                              |  |  |                                       |   |                                 |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |                              | First Middle Last  |  |                                       | 2a. DATE OF DEATH   |                                 |  | 2b. HOUR a.                                  |
| WILLIAM  |  |                              | McKINLEY   |  |                                       | WOLF  |                                 |  | 7:00 PM                                      |
| 3. SEX   |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                       |   | 6. AGE (In years last birthday) |  | 7. YRS.                                      |
| MALE   |  | WHITE                        |  | 8 13 904   |                                       |   | 73                              |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       |   | 9. COUNTY OF DEATH              |  |  |
| MARYLAND   |  | U.S.A.                       |  |  |                                       |   | BALTIMORE Md.                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                       | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY            |
| FORT HOWARD  |  |                              | VETERANS ADM. HOSPITAL   |  |                                       | AUTO MECHANIC   |                                 |  | Retired                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |                              |  | 13b. COUNTY  |                                       | 13c. CITY OR TOWN   |                                 | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER                       |
| MARYLAND   |  |                              |  |  |                                       | BALTIMORE   |                                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          | 3541 BENZINGER ROAD                          |
| 14. FATHER'S NAME  |  |                              | 15. MOTHER'S MAIDEN NAME   |  |                                       |   |                                 |  |  |
| First Middle Last  |  |                              | First Middle Last  |  |                                       |   |                                 |  |  |
| ERNEST A WOLF  |  |                              | ISABELLE DILSWORTH   |  |                                       |   |                                 |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |                              | 16b. SOCIAL SECURITY NO.   |  |                                       | 17. INFORMANT   |                                 |  |  |
| YES or unknown) WW-1   |  |                              | 219 01 7563  |  |                                       | Mrs. Anna A. Boffen 308 Dover Rd MD. CLIN. REG. VET. ADM. HOSP. FORT HOWARD             |                                 |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                              |  |  |                                       |   |                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:   |  |                              |  |  |                                       |   |                                 |  | 16 DAYS                                      |
| IMMEDIATE CAUSE (a) RENAL FAILURE  |  |                              |  |  |                                       |   |                                 |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |                                       |   |                                 |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |                              |  |  |                                       |   |                                 |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |                              |  |  |                                       |   |                                 |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |                              |  |  |                                       |   |                                 |  |  |
| GASTROINTESTINAL BLEEDING  |  |                              |  |  |                                       |   |                                 |  |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                       | 20a. AUTOPSY?   |                                 | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 2 8 68   |  |                              | AORTIC PLAQUE  |  |                                       | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |                                 |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |                              | 21b. TIME OF INJURY  |  |                                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)         |                                 |  |  |
|  |  |                              | HOUR A.M. Month Day Year P.M. 19   |  |                                       |   |                                 |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                       | 21f. LOCATION Street or R.F.D. No. City or Town County State                            |                                 |  |  |
|  |  |                              |  |  |                                       |   |                                 |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from Jan. 22, 1968, to Feb. 24, 1968, that (X) (we) last saw the deceased alive on Feb. 24, 1968, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                       |   |                                 |  |  |
| 22b. SIGNATURE   |  |                              |  |  |                                       |   |                                 | 22c. DATE SIGNED   |  |
| Ralph M. Howard, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  |                              |  |  |                                       |   |                                 | 2 24 68  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |                              |  |  |                                       | 22e. ADDRESS  |                                 |  |  |
| RALPH M. HOWARD, M. D.   |  |                              |  |  |                                       | VAH, FORT HOWARD, MARYLAND  |                                 |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY    |   |                                 | 23d. LOCATION (City or Town) (County) (State)  |  |
| BURIAL   |  |                              | 2/28/68  |  | BALTIMORE NATIONAL CEMETERY BALTIMORE |   |                                 | MARYLAND   |  |
| 24. FUNERAL DIRECTOR   |  |                              |  |  | 25a. REC'D BY REGISTRAR               |   | 25b. REGISTRAR'S SIGNATURE      |  |  |
| Hubbard Funeral Home 4107 Wilkens Ave. Baltimore, Md. 21229  |  |                              |  |  | DATE FEB 29 1968                      |   | Charles Judge                   |  |  |

11650

© 1997 American Psychological Association

1961 04 21 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |   |  |                                |
|---|--|---|--|---|--|---|--|---|--|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |   |  |                                |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |                                |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>JOHN   |  | Middle<br>TALIAFERRO  |  | Last<br>WORTH   |  | 2a. DATE OF DEATH<br>Month 2 Day 14 Year 68   |  | 2b. HOUR<br>1 P.M.             |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>Jan. 12, 1914   |  | 6. AGE (In years last birthday)<br>54 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                |  | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br>Ky.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Baltimore   |  | Md.   |  |                                |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>202 1/2 Bosley Ave.                             |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Trans. Manager   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Towson   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br>202 1/2 Bosley Ave. |  |                                |
| 14. FATHER'S NAME First Middle Last<br>John G. Worth  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Phoebe Beckner  |  |   |  |   |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br>403-05-9897   |  | 17. INFORMANT Address<br>Mrs. Shirley A. Worth, Same as #13   |  |   |  |   |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral vascular thrombosis</u><br>4129 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>acute</u><br><u>10 XAS</u> |  |   |  |   |  |   |  |   |  |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4221  |  |   |  |   |  |   |  |   |  |                                |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |   |  |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |  |                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT</u> , 19 <u>68</u> , to <u>PRESENT</u> , 19 <u>68</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>2/8</u> , 19 <u>68</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.                   |  |   |  |   |  |   |  |   |  |                                |
| 22b. SIGNATURE<br><u>Leon G. Sheer, M.D.</u> DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>2/14/68</u>  |  |   |  |   |  |                                |
| 22d. PHYSICIAN'S NAME (Type)<br>LEON G. SHEER, M.D.   |  | 22e. ADDRESS<br>6715 PARK HEIGHTS AVE.  |  |   |  |   |  |   |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br>Feb. 15, 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenmount Crematory  |  | 23d. LOCATION (City or Town) (County) (State)<br>Baltimore, Maryland                            |  |   |  |                                |
| 24. FUNERAL DIRECTOR<br>Wm. Cook-Brooks Towson, 1050 York Road<br>son, 21204  |  | ADDRESS   |  | 25a. RECEIVED BY REGISTER<br>DATE   |  | 25b. REGISTER'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |                                |

8220

RECEIVED BY USARV

10490

RECEIVED BY USARV

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div> <div>Item 21 film 398</div> <div>3-6-68 mt</div> <div>02402</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>02389</div> </div>  |         |  |  |  |   |   |  |  |  |  |  |
|--|---------|--|--|--|---|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)  |         |  | First Middle Last  |  |   | 2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 2 25 19 68 1:00a                     |  |  | 2b. HOUR                                   |  |  |
| HARRISON   |         |  | FILMORE  |  |   | WYATT   |  |  |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS  |   | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD<br>Month Day Year |  |  |
| Male   | White   | 2-7-1918   |  | 50 YRS.  |   |   |  |  | Feb. 25 19 68 1:00                         |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |  |  |  |
| Baltimore, Md.   |         |  | U.S.A.   |  |   |   | Balto. Md.   |  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY          |  |  |
| Balto. 21204   |         |  | 619 Piccadilly Rd.   |  |   | B&O, C&O, Director Personell  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER                     |  |  |
| Md.  |         |  | Balto.   |  | Balto.  |   |  |  | 619 Piccadilly Rd.                         |  |  |
| 14. FATHER'S NAME First Middle Last  |         |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last  |   |  |  |  |  |  |
| Harrison Wyatt   |         |  |  |  | Pearl Hill Denbow   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |         |  |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |  |  |  |  |
| Yes. Navy, 11  |         |  |  |  |   |   | Hospital Records   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Subarachnoid hemorrhage<br>880X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |         |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>9000  |         |  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |         |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                  |   |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |         |  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>1:00 xx 2 25 19 68            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br>Subject fell down stairs |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br>Home |  | 21f. LOCATION Street or R.F.D. No. City or Town County State<br>Baltimore Balto Md |   |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |  |  |   |   |  |  |  |  |  |
| ACTUAL SIGNATURE <i>Edward F. Wilson</i>   |         |  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>                               |   |   |  | 22b. DATE SIGNED   |  |  |  |
| EXAMINER'S NAME (Type) Edward F. Wilson, M.D.  |         |  |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>                                   |   |   |  | Feb. 25, 1968  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |         |  |  | 23b. DATE<br>2-27-1968   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Lorraine  |  | 23d. LOCATION (City or Town) (County) (State)<br>Woodlawn Balto, Md.             |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br>Wm. Cook-Brooks Towson, Towson, Md.  |         |  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 29 1968   |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                                  |  |  |  |

18000

RECEIVED

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800

0800



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me (under number 1), page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |  |                                   |  |  |
|--|--|--|--|--|---|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |                                   |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |                                   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  | 2b. HOUR                          |  |  |
| LENA   |  |  | NMI Yaffe  |  |   | Month Day Year<br>2-13-1968   |  | 4:30 P.M.                         |  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  |  |
| FEMALE   |  | WHITE  |  | 5-15-92  |   | 75 YRS.   |  | IF UNDER 24 HRS<br>HOURS MIN      |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                                   |  |  |
| RUSSIA   |  | U.S.A.   |  |  |   | BALTIMORE Md.   |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Randalls Town  |  |  | BALTIMORE Co. Gen. Hosp.   |  |   | RETIRED   |  | CLOTHING                          |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| Md.  |  |  | BALTIMORE  |  | BALTIMORE   |   | YES  |                                   | 6500 Eberle Dr.                              |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |                                   |  |  |
| First Middle Last  |  |  | First Middle Last  |  |   |   |  |                                   |  |  |
| BENJAMIN YAFFE   |  |  | RACHEL JACOBSON  |  |   |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |   | Address  |                                   | #21215                                       |  |
| NO   |  |  | 213-09-7094  |  | MRS. SHIRLEY YAFFE  |   | 6500 EBERLE DR., APT. 203  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION  |  |  |  |  |   |   |  |                                   |  |  |
| 4109 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |   |   |  |                                   |  |  |
| (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE  |  |  |  |  |   |   |  |                                   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |  |                                   |  |  |
| (c)  |  |  |  |  |   |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |   |   |  |                                   |  |  |
| 4201   |  |  |  |  |   |   |  |                                   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
|  |  |  |  |  |   |   |  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |                                   |  |  |
|  |  |  |  |  |   |   |  |                                   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |   | City or Town  |  | County State                      |  |  |
|  |  |  |  |  |   |   |  |                                   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from FEB 8, 1968, to FEB 13, 1968, that (I) (we) last saw the deceased alive on FEB 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |  |                                   |  |  |
| 22b. SIGNATURE   |  |  |  |  |   |   |  | 22c. DATE SIGNED                  |  |  |
| Fausto Q. Aquino   |  |  |  |  |   |   |  | 2-13-68                           |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  |   |   |  | 22e. ADDRESS                      |  |  |
| FAUSTO Q. AQUINO JR.   |  |  |  |  |   |   |  | BALTIMORE COUNTY GEN. HOSP.       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| BURIAL   |  | 1-14-68  |  | HEBREW MT. CARMEL  |   | BALTIMORE, MARYLAND   |  |                                   |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE        |  |  |
| SOL LEVINSON & BROS.,  |  |  |  | 6010 REISTERSTOWN ROAD   |   | FEB 14 1968   |  | Charles Judge                     |  |  |

20450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |  |  |  |  |   |                             |
|---|--|--|---|--|--|--|--|--|--|---|-----------------------------|
| CERTIFICATE OF DEATH  |  |  |   |  |  |  |  |  |  |   |                             |
| 1. DECEASED-NAME (Type or print) <b>MINNIE ZASLOUSKY</b>  |  |  |   |  |  | 2a. DATE OF DEATH <b>FEB 18 1968</b>   |  |  | 2b. HOUR <b>11:35 PM</b>                         |   |                             |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>WHITE</b>   |   | 5. DATE OF BIRTH <b>DECEMBER 27, 1883</b>  |  |  | 6. AGE (In years lost birthday) <b>84</b> YRS. |  | IF UNDER 1 YEAR MONTHS DAYS                      |   | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>BALTIMORE</b> Md.  |  |  |  |   |                             |
| 10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4025 STARBROOK ROAD</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b> |   |                             |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>   |  |  | 13b. COUNTY <b>BALTIMORE</b>  |  |  | 13c. CITY OR TOWN <b>RANDALLSTOWN</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER <b>4025 STARBROOK ROAD</b>             |                             |
| 14. FATHER'S NAME First <b>DAVID</b> Middle <b>KARCHEM</b> Last <b>SARAH</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME First <b>SARAH</b> Middle <b>?</b> Last <b>?</b>  |  |  |  |  |  |   |                             |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)  |  |  |   | 16b. SOCIAL SECURITY NO. <b>213-05-6323D</b>   |  | 17. INFORMANT Address <b>MRS. IRENE F. HESS, 4025 STARBROOK RD. #21133</b>                               |  |  |  |   |                             |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>7230</b> IMMEDIATE CAUSE (a) <b>Silental bronchopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Advanced Paget's disease with aspergillus 4 months</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>lost.</b>                            |  |  |   |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b> |                             |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>131X</b>  |  |  |   |  |  |  |  |  |  |   |                             |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |   |                             |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |   |                             |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |   |                             |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/5</b> , 19 <b>68</b> , to <b>2/19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |  |   |                             |
| 22b. SIGNATURE <b>Stanley M. Rosen M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |   |  |  | 22c. DATE SIGNED <b>2/19/68</b>  |  |  |  |   |                             |
| 22d. PHYSICIAN'S NAME (Type) <b>STANLEY M. ROSEN, M.D.</b>  |  |  |   |  |  | 22e. ADDRESS <b>4000 W. Northern Pkwy (15)</b>   |  |  |  |   |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 23b. DATE <b>2-20-68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>TZEMECH ZEDEK</b>  |  | 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>                                 |  |  |  |   |                             |
| 24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  |  |   | ADDRESS  |  | 25a. REC'D BY REGISTRAR <b>DATE FEB 20 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>                                     |  |   |                             |

